

11552

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3704 Farragut ST. W</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Aebersold</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881 - 3/12 1900</u> yrs.	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. TRANSIT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Motorman</u>		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Rudolph Aebersold</u>				14. MOTHER'S MAIDEN NAME <u>MARIE WEBER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-6619A</u>			
17. INFORMANT <u>Robert Aebersold, Son-same 2d</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>yes</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(6/1/55)</u>	
20f. (City or town) <u>Kensington</u>				20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1955</u> to <u>10/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>60</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Allen</u>				ADDRESS (Street, city or town, state) <u>Kensington, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Samuel Allen, M.D.</u>				DATE SIGNED <u>10/20/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>OCT 24 '60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11503

11503

STATE OF NEW YORK

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONER OF HEALTH

FOR THE YEAR 1899

ALBANY:

1900

PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

PRINTING OFFICE

ALBANY

1900

1900

1900

1900

1900

1900

1900

1900





11:24

CERTIFICATE OF DEATH

11:24

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

DATE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

*[Handwritten signature and text]*

DATE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

11562

11485

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>7hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>15510 Georgia Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>(Twin "B")</b>		Middle <b>ALDERTON</b>		Last <b>ALDERTON</b>	
4. DATE OF DEATH		Month <b>October</b>		Day <b>19</b>		Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-60</b>	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip Frederick ALDERTON</b>		14. MOTHER'S MAIDEN NAME <b>Judith Ann DICKIE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>(F) Phillip F. Alderton, same as #2 above</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (twin gestation at 26 weeks)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>attested</del> attended the deceased from <b>Oct. 18 6:18pm</b> to <b>Oct. 19 1960</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Oct. 19 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Lawrence G. Thorne</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence G. THORNE, LT, MC, BSN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-24-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) <b>Arlington</b>		23e. (State) <b>Virginia</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>	
24a. ADDRESS <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		24b. REC'D BY REGISTRAR DATE <b>OCT 24 '60</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>			

2251183xvo

11482

11482

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

Dr Brochart Notified

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
11563					11486									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE									
MONTGOMERY					MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
BETHESDA					KENSINGTON									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
SUBURBAN HOSPITAL					10610 Parkwood Drive									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
EDITH ANDERSON					OCTOBER 31 1960									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.						
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/4/91		68						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
CHANCELLOR - RETIRED			-			Minn.			U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
David Anderson					Amanda Johnson									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No										Mrs. E. Andahl (Moline, Ill.) (Sister)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection, Small Intestine DUE TO Volvulus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Surgical adhesions (more than 4 yrs) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 48 hrs.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)					
Hour a. m. p. m.			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
21. I certify that (I) (this hospital) attended the deceased from Oct 30, 1960 to Oct 31, 1960 that (I) (we) last saw the deceased alive on Oct 30, 1960, and that death occurred at 5:00 PM, from the causes and on the date stated above.														
22a. SIGNATURE					22b. ADDRESS		22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED					
Robert T. Thibadeau					10609* Concord Kensington, Md		Robert T. Thibadeau							
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)					
Removal					11-2-1960		Riverside Cemetery		Moline, Ill.					
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph Gustafson					1756 Palisades NW		DATE NOV 3 '60		Arthur L. Kraus					



11488

CERTIFICATE OF DEATH

11488

11488

11488

CHIEF OF POLICE

DEPT. OF HEALTH

CITY OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11564  
11487  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 mo 4 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Altal Vista Nursing Home</u>		d. STREET ADDRESS <u>55 Cherry Chase</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Bauer</u> Last <u>Arthur</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 27, 1886</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Bauer</u>		14. MOTHER'S MAIDEN NAME <u>Ida Handberry Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Wm. C. Arthur</u>		Address <u>5706 Warwick Pl. Cherry Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction, Massive</u> 464x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Phlebotrombosis, same as?</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dilated Nodules &amp; Arteriosclerosis, generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>60</u> , to <u>10/15</u> 19 <u>60</u> that (I) <u>was</u> last saw the deceased alive on <u>10/13</u> 19 <u>60</u> , and that death occurred at <u>12:29</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Luther Hall</u>		22b. DATE SIGNED <u>10/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Luther Hall</u>		22d. ADDRESS <u>5410 Conn. Ave. Wash 15, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>OCT 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11584

CERTIFICATE OF DEATH

11584



George A. Campbell, Bettsburg, Maryland  
Born 10/10/00 Bettsburg, Maryland  
Died 10/10/00 Bettsburg, Maryland  
Cause of Death: ...  
Buried in ...  
Witnessed by ...  
Signed and sealed ...  
Registrar of Deaths ...

## CERTIFICATE OF DEATH

11488  
Reg. Dist. No.

11546

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3808 Underwood Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>SHREEVE</b> Last <b>AUSTIN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18,</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1878</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patent Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James Brown Austin</b>				14. MOTHER'S MAIDEN NAME <b>Shepherd H. Handy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Daughter</b> <b>Miss Marion Austin</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO (c) <b>Carcinoma STOMACH, LIVER</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>1-year</b> <b>1+ year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIO SCLEROSIS, GENERALIZED</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>16 OCT., 1960</b> , to <b>18 OCT., 1960</b> , that I last saw the deceased alive on <b>18 OCT., 1960</b> , and that death occurred at <b>10:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles J. Savarese</b>				M.D. <b>4890 BATTERY LANE</b>		DATE SIGNED <b>10/19/60</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVARESE, M.D.</b>				<b>BETHESDA, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 21 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11489  
11565  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7514 Marbury Road</b>		d. STREET ADDRESS <b>7514 Marbury Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Titus</b> Last <b>Aylward</b>		4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/1879</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	11. BIRTHPLACE (State or foreign country) <b>Maine</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Frank Aylward</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Titus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>024-10-0628</b>	
17. INFORMANT <b>Olive Aylward-wife-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS.</b> <b>4 YRS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>MARCH 1959</b> to <b>OCT 1960</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>OCT. 8 1960</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Leo M. Curtis</b>		22b. DATE SIGNED <b>OCT. 9, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo M. Curtis</b>		22d. ADDRESS <b>8218 WISCONSIN AVE, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		23b. DATE THEREOF <b>10/12/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Puritan Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Peabody, Massachusetts</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24. ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

11-152

CERTIFICATE OF DEATH

11-152

Deceased: *[Illegible]*  
Date of Death: *[Illegible]*  
Place of Death: *[Illegible]*  
Cause of Death: *[Illegible]*  
Age: *[Illegible]*  
Sex: *[Illegible]*  
Race: *[Illegible]*  
Occupation: *[Illegible]*  
Marital Status: *[Illegible]*  
Signature: *[Illegible]*  
Witness: *[Illegible]*  
Registrar: *[Illegible]*

11490

11503

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>M</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>3 WEEKS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ATLANTA WOODLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>47X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON - D.C.</b> d. STREET ADDRESS <b>3825 HARRISON ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>BATURIN</b> Last <b>BATURIN</b>				4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 8, 1882</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BAER, ARMERAN</b>				14. MOTHER'S MAIDEN NAME <b>HELEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		INFORMANT <b>EDGAR BATURIN - 3825 HARRISON ST. N.W.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days.</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 11, 1960</b> , to <b>Oct. 27, 1960</b> , that I last saw the deceased alive on <b>10-27-60</b> , 19 <b>60</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gene U. Cohen</b>		ADDRESS (Street, city or town, state) <b>931 Pershing Drive, Silver Spring, Md.</b> DATE SIGNED <b>Oct 28, 1960.</b>					
PHYSICIAN'S NAME (Type) <b>GENE U. COHEN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-30-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ADAS ISRAEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON - D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY + SONS - 3501-14th ST. N.W.</b>				24a. REC'D BY REGISTRAR <b>NOV 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11503

CERTIFICATE OF CLAIM

11503

Warranted by the  
State of California  
to the  
Bureau of Land Management  
for the purpose of  
claiming the  
rights of the  
United States  
in the  
lands of the  
State of California  
under the  
Act of March 3, 1879,  
Chapter 249,  
Section 2324.

For the purpose of  
claiming the  
rights of the  
United States  
in the  
lands of the  
State of California  
under the  
Act of March 3, 1879,  
Chapter 249,  
Section 2324.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

11504

CERTIFICATE OF DEATH

11491

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>8 yrs.</b>		d. STREET ADDRESS <b>8304 16th Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8304 16th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Cornelius</b> First <b>Beard</b> Middle Last		4. DATE OF DEATH <b>Oct 7 1960</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius Beard</b>		14. MOTHER'S MAIDEN NAME <b>Anais Bonabel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW #1 &amp; # 2 229-14-8663</b>	
17. INFORMANT <b>Mrs. Amy L. Beard, 8304 16th Street</b> Address <b>Silver Spring, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 420.1 DUE TO <b>coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>10 yrs.</b> (c) <b>6 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1951</b> to <b>Oct 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Feb 7 1960</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. F. Kreuzburg</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b>		22d. ADDRESS <b>2852 16th St NW Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC. SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



11401

CERTIFICATE OF DEATH

11401

(M)

STATE OF NEW YORK  
COUNTY OF [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]

That [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]

Witness my hand and seal of office this [illegible] day of [illegible] 19[illegible]

Notary Public for the State of New York

Subscribed and sworn to before me this [illegible] day of [illegible] 19[illegible]

My commission expires this [illegible] day of [illegible] 19[illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11518  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11492

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Parker Bladen</u>		4. DATE OF DEATH <u>10-17-60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1903</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Daly &amp; Bent Construction Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr Joseph Bladen</u>		14. MOTHER'S MAIDEN NAME <u>RE Emma Paxsley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-2738</u>	
17. INFORMANT <u>Helen A. Powell</u>		Address <u>8903 RIGGS RD. HYATT MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis (1954)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>17 Oct 1960</u> , that (I) (we) last saw the deceased alive on <u>14 Oct 1960</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. Aud</u> M.D.		22b. DATE SIGNED <u>10/17/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/20/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PR INCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11566

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11493

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>Since 9/28/60</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>34 Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>112718 Gould Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Catherine Bowers</i>				4. DATE OF DEATH Month Day Year <i>Oct. 21 1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 24 1906</i>	
9. AGE (In years last birthday) <i>54 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store own home</i>		11. BIRTHPLACE (State or foreign country) <i>Mont. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles W. Brown</i>				14. MOTHER'S MAIDEN NAME <i>Alice May Disney</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>579-07-9104</i>		17. INFORMANT Address <i>Francis E. Davis / son</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i> DUE TO <i>Neuratic failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis of the brain</i> DUE TO <i>10 yrs</i> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>6 wks</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 28, 1960</i> to <i>Oct 21, 1960</i> that (I) (we) last saw the deceased alive on <i>Oct 21, 1960</i> , and that death occurred <i>6:30</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Horace W. Bernton</i>				22b. DATE SIGNED <i>10/22/60</i>		22c. PHYSICIAN'S NAME (Type) <i>HORACE W. BERNTON</i>	
22d. ADDRESS <i>10511 Summit Ave., Kensington, Md.</i>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10/24/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Werner E. Pumphrey, Inc.</i>				25a. REC'D BY REGISTRAR <i>Oct 25 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

11423

11368

1



1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13 Rockville (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Lane</u>		d. STREET ADDRESS <u>1 Emory Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Henry Boyer</u>		4. DATE OF DEATH <u>Oct 6 1960</u>	
5. SEX <u>Male</u>		6. AGE (In years last birthday) <u>69</u> yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1891</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabner</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. FATHER'S NAME <u>Mamuel Boyer</u>		10b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. SOCIAL SECURITY NO.	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		14. INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Surwiler</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		DATE <u>OCT 13 '60</u>	

11100

11100

RECEIVED  
JAN 10 1941



W. J. ...

...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11567

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Silver Spring.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>12703-Lindell St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/42</u>		9. AGE (In years last birthday) <u>17</u> yrs.	10. IF UNDER 1 YEAR: Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wheaton High School</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry E. Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Thayer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Perry E. Bradley</u> Address <u>Same 25 Above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lymphosarcoma</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 months</u> DUE TO (c) <u>Interval between onset and death</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1959</u> to <u>Oct 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 27, 1960</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip E. Jones</u>				22b. DATE SIGNED <u>Oct 27, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>PHILIP E. JONES</u>	
22d. ADDRESS <u>918 Ellsworth Drive, Silver Spring, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>918 Ellsworth Drive, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Nov 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

M

1

1

ap

11507

CERTIFICATE OF DEATH

11507

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11519

CERTIFICATE OF DEATH

11496

Item 6 Film 273 10-26-60 et

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington San. and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Mont.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>15730 Peach Orchard Vrd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Agnes Agnus Loretta Brady</b>		4. DATE OF DEATH Month Day Year <b>Oct 14 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-97</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Blauvelt</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Mc Donnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Hypertensive Pneumonia</b> DUE TO <b>60 of Large Blood @ metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Septicemia</b> DUE TO (c) <b>Septicemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio Sclerotic CV Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>?</b> <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 29 1960</b> to <b>Oct 14 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 13 1960</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Raul E. Janet</b>		22b. DATE SIGNED <b>10-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAUL JANET MD</b>		22d. ADDRESS <b>6127-16th St. N.W. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pimphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 19 '60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>	



11430

CERTIFICATE OF DEATH

11430

1

1

1



1  
FOR STATE  
HEALTH DEPT.

TO DEPOSIT: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11568

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11497

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>48 Bethesda</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4707 Chevy Chase Dr</i>				d. STREET ADDRESS <i>14707 Chevy Chase Dr</i>			
3. NAME OF DECEASED (Type or print) <i>Ward W. Brewer</i>		4. DATE OF DEATH <i>Oct 18 1960</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12-24-08</i>	9. AGE (in years last birthday) <i>51</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman unemployed</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Conn.</i>	
13. FATHER'S NAME <i>Harry J. Brewer</i>				14. MOTHER'S MAIDEN NAME <i>Hattie ? Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joel P. Brewer</i>		Address <i>4707 Ch. Ch., Dr. Bethesda, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>Found dead on floor at home</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>History of previous C.V.A.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>10-18-60</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>10-20-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or country) (State) <i>Prince George Co., Md.</i>	
23. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>				ADDRESS <i>Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>OCT 24 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

83611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

11569

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11498

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>906 P Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>(None)</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1907</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Grannison</b>		14. MOTHER'S MAIDEN NAME <b>Susan Elam</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Bacteremic Shock</b> DUE TO (c) <b>Carcinoma of Cervix</b>		INTERVAL BETWEEN ONSET AND DEATH <b>53 Hrs.</b> <b>53 Hrs.</b> <b>20 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary and Intestinal Fistula, Renal Shutdown, Post-operative</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 7, 1960</b> to <b>October 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 13, 1960</b> , and that death occurred at <b>4:25 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David T. Crawford</b>		22b. DATE SIGNED <b>10-13-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID T. CRAWFORD, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-17-60 Natl. Harmony Memorial</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick's Funeral Home Inc. 389 R. 2 Ave. NW</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 '60</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

11008

CERTIFICATE OF DEATH

11008



Blank certificate form with faint horizontal lines and vertical columns for data entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11570

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11499

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (Rural)</b>		c. LENGTH OF STAY IN 1b <b>15</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ULYESSES</b> Middle <b>BROWN</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1866</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months <b>94</b> Days <b>94</b> Hours <b>94</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Nursing Home Records</b>	
17. INFORMANT <b>Nursing Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>422.2</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Chronic Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , 19 <b>1959</b> , to <b>Oct 2</b> , 19 <b>1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 1</b> , 19 <b>1960</b> , and that death occurred at <b>7P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Luciano L. Leal</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Luciano L. Leal</b>		22d. ADDRESS <b>Gaithersburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/6/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove.,</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Zion, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swander</b>		ADDRESS <b>Rockville, Md.</b>	
25a. REC'D BY REGISTRAR <b>DATE OCT 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3, page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A13ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11500

Reg. Dist. No.

11571

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg, Md.</u>		d. STREET ADDRESS <u>Route 55—Hammerhill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Ira Burnett</u>		4. DATE OF DEATH Month Day Year <u>October 11, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 29, 1944</u>
9. AGE (In years last birthday) <u>16 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas H. Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Thomas Burnett (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hemorrhage &amp; laceration</u> DUE TO (b) <u>bullet wound in skull</u> DUE TO (c) <u>bullet wound in skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted bullet wound</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>10-10-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Clarksburg monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-12-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		24a. REC'D BY REGISTRAR <u>Oct 13 '60</u>	
ADDRESS <u>Gaithersburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

155  
A.M.

3 1/2 hrs.

0

Y

BP

11580

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11581

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT'S NAME: \_\_\_\_\_

2. SEX: ☐ Male ☐ Female

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

8. PRESENT ILLNESS: \_\_\_\_\_

9. HISTORY OF PRESENT ILLNESS: \_\_\_\_\_

10. PREVIOUS ILLNESSES: \_\_\_\_\_

11. MEDICAL HISTORY: \_\_\_\_\_

12. SURGICAL HISTORY: \_\_\_\_\_

13. MEDICATIONS: \_\_\_\_\_

14. ALLERGIES: \_\_\_\_\_

15. SOCIAL HISTORY: \_\_\_\_\_

16. PHYSICAL EXAMINATION: \_\_\_\_\_

17. LABORATORY TESTS: \_\_\_\_\_

18. RADIOLOGIC TESTS: \_\_\_\_\_

19. PATHOLOGIC FINDINGS: \_\_\_\_\_

20. CAUSE OF DEATH: \_\_\_\_\_

21. MANNER OF DEATH: \_\_\_\_\_

22. SIGNATURE OF EXAMINER: \_\_\_\_\_

23. DATE: \_\_\_\_\_

Vertical text on the right margin, likely a filing or processing note.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11572

11501

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Johnstown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Johnstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		d. STREET ADDRESS <b>606 Warner Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>(none)</b> Last <b>Burrafato</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1943</b>
9. AGE (In years last birthday) <b>16</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>George Burrafato</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Maria) Sunsero</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>The Clinical Center, Bethesda 14, Maryland</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary Pulmonary Hypertension</b> DUE TO (c) <b>Primary Pulmonary Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>45 Minutes</b> <b>2 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 5, 1960</b> to <b>October 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 6, 1960</b> , and that death occurred at <b>12 Noon</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Levine M.D.</b>		22b. DATE SIGNED <b>10-7-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Levine, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 10-7-60</b>		23b. DATE THEREOF <b>10-7-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Johnstown, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

† *ca. 5052*

502

vinyl

411

George Durrant

Harry (Orelia) Gurnea

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

October 6, 1960

44

© 1997 by The American Psychological Association

Institute of Health, Bethesda 14, Maryland

• • •

11573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan</u>		4. DATE OF DEATH <u>10</u> <u>11</u> <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/58</u>
9. AGE (In years last birthday) <u>2 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford C. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Jane Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jane Butler</u>		Address <u>mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Herniation of Brain Stem</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracerebral edema</u> DUE TO (c) <u>Epidural Hematoma, left</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Not known</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>?</u> <u>?</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda</u>	20f. (City or town) (County) (State) <u>Montg.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11-573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-573

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. MANNER OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. PLACE OF DEATH</p> <p>16. SIGNATURE OF EXAMINER</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF JUDGE</p> <p>21. SIGNATURE OF CLERK</p> <p>22. SIGNATURE OF SHERIFF</p> <p>23. SIGNATURE OF DEPUTY SHERIFF</p> <p>24. SIGNATURE OF CONSTABLE</p> <p>25. SIGNATURE OF JAILER</p> <p>26. SIGNATURE OF PRISONER</p> <p>27. SIGNATURE OF GUARD</p> <p>28. SIGNATURE OF WARDEN</p> <p>29. SIGNATURE OF CHIEF CLERK</p> <p>30. SIGNATURE OF ASSISTANT CLERK</p> <p>31. SIGNATURE OF RECEPTIONIST</p> <p>32. SIGNATURE OF MAIL ROOM</p> <p>33. SIGNATURE OF TELEPHONE ROOM</p> <p>34. SIGNATURE OF JANITOR</p> <p>35. SIGNATURE OF NIGHT WATCHMAN</p> <p>36. SIGNATURE OF PORTER</p> <p>37. SIGNATURE OF CLEANER</p> <p>38. SIGNATURE OF COOK</p> <p>39. SIGNATURE OF BUTLER</p> <p>40. SIGNATURE OF HOUSEKEEPER</p> <p>41. SIGNATURE OF GARDENER</p> <p>42. SIGNATURE OF CARPENTER</p> <p>43. SIGNATURE OF PAINTER</p> <p>44. SIGNATURE OF ELECTRICIAN</p> <p>45. SIGNATURE OF PLUMBER</p> <p>46. SIGNATURE OF MECHANIC</p> <p>47. SIGNATURE OF TAILOR</p> <p>48. SIGNATURE OF HAT MAKER</p> <p>49. SIGNATURE OF SHOEMAKER</p> <p>50. SIGNATURE OF JEWELER</p> <p>51. SIGNATURE OF OPTICIAN</p> <p>52. SIGNATURE OF DENTIST</p> <p>53. SIGNATURE OF PHYSICIAN</p> <p>54. SIGNATURE OF NURSE</p> <p>55. SIGNATURE OF MIDWIFE</p> <p>56. SIGNATURE OF DOCTOR</p> <p>57. SIGNATURE OF SURGEON</p> <p>58. SIGNATURE OF VETERINARIAN</p> <p>59. SIGNATURE OF FARMER</p> <p>60. SIGNATURE OF LABORER</p> <p>61. SIGNATURE OF MERCHANT</p> <p>62. SIGNATURE OF MANUFACTURER</p> <p>63. SIGNATURE OF MINISTER</p> <p>64. SIGNATURE OF PASTOR</p> <p>65. SIGNATURE OF CHURCH WARDEN</p> <p>66. SIGNATURE OF SCHOOL TEACHER</p> <p>67. SIGNATURE OF SCHOOL PRINCIPAL</p> <p>68. SIGNATURE OF SCHOOL BOARD MEMBER</p> <p>69. SIGNATURE OF SCHOOL BOARD CHAIRMAN</p> <p>70. SIGNATURE OF SCHOOL BOARD SECRETARY</p> <p>71. SIGNATURE OF SCHOOL BOARD CLERK</p> <p>72. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>73. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>74. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>75. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>76. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>77. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>78. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>79. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p> <p>80. SIGNATURE OF SCHOOL BOARD MEMBER AT LARGE</p>	
---	--



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11503

11574

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Jamestown</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jamestown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>RD #1</b>		e. IS RESIDENCE ON A FARM? YES <b>XX</b> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Mark</b> Middle <b>Allen</b> Last <b>CAMPBELL</b>		4. DATE OF DEATH		Month <b>OCTOBER</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-23-59</b>		9. AGE (In years lost birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Herman CAMPBELL</b>				14. MOTHER'S MAIDEN NAME <b>Leticia Roseann PRESTO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Paul H. CAMPBELL, 22 Barnacle Green, Wash, D.C.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE, GASTROINTESTINAL</b> DUE TO <b>204.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LEUKEMIA, ACUTE LYMPHOGEN.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>7-20-</b> <b>19 60</b> to <b>10-1-</b> <b>19 60</b> , that <b>1</b> (we) last saw the deceased alive on <b>10-1-</b> <b>19 60</b> and that death occurred at <b>2:48 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Rack</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-1-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. RACK, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>10/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic</b>		23d. LOCATION (City, town, or county) (State) <b>Greenville, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS, 1400 Chapin St., N.W., Wash. D.C.</b> ADDRESS				25a. REC'D BY REGISTRAR <b>OCT 3 1960</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Brown</b>	

MEDICAL CERTIFICATION

11508

11574

Pennsylvania

Lawrence

10-1-50

Rebecca (Hunt)

U.S. Naval Hospital

10-1-50

Overman

Alton

Walt

1-25-50

Emerson

Walt

Pennsylvania

10-1-50

Carl

John H. Bushman

Paul H. Bushman

Paul H. Bushman, 100 Bushman Street, 100

Walt

Walt

10-1-50

10-1-50

Robert V. Brock, Jr., MD, PhD

U.S. Naval Hospital, Baltimore, Md.

Carl

Carl

W. V. Brock, Jr., 1000 Chapel St., N.Y., Wash. D.C.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11575  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11504

1. PLACE OF DEATH a. COUNTY <b>M MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN Hospital</b>			d. STREET ADDRESS <b>10 ROSEMONT DR.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OPAL</b> Middle <b>M</b> Last <b>CAMPBELL</b>			4. DATE OF DEATH Month <b>OCT</b> Day <b>18</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/ 31/22</b>	9. AGE (In years lost birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Minn.</b>	
13. FATHER'S NAME <b>Rudolph Kruger</b>			14. MOTHER'S MAIDEN NAME <b>Clara Scherer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Cyril Campbell-Husband-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>576X</b> IMMEDIATE CAUSE (a) <b>OVERWHELMING TOXEMIA?</b> DUE TO (b) <b>PRIMARY PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-17-1960</b> to <b>10-18-1960</b> , that (I) (we) last saw the deceased alive on <b>10-18-1960</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>J. P. McCarrick M.D.</b>			22b. DATE SIGNED <b>10-18-60</b>		22c. PHYSICIAN'S NAME (Type) <b>J. P. McCarrick MD</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>10/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			24b. ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 21 '60</b>
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>					

11501

11551

1

10/21/50  
J. P. McGowan  
Rockville, Md.  
Rockville, Md.  
Rockville, Md.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S.E. Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>(Infant)</u> Middle <u>Carico</u> Last <u>Carico</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-60</u>
9. AGE (In years lost birthday) yrs. <u>—</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>12</u> Days <u>5</u> Hours <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Washington</u>		14. MOTHER'S MAIDEN NAME <u>Jeane Katherine Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMATION <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stelecstarin (pulmonary hyaline membrane)</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>60</u> , to <u>10/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christenson</u> M.D.		DATE SIGNED <u>10/21/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christenson, M. D.</u>		<u>College Park, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. &amp; Hosp. Tk Pk, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraus</u>			

2075225XU3

20511



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

11576

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11506

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>49 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>83 X - 3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>886 N. Kensington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Backstrom CASSEDY</b>				4. DATE OF DEATH Month Day Year <b>October 22 1960</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-23-08</b>		9. AGE (In years last birthday) <b>52</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>				11. BIRTHPLACE (State or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Theodore Edward BACKSTROM</b>				14. MOTHER'S MAIDEN NAME <b>Helen RICHARDS</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unk</b>				17. INFORMANT <b>Hiram Cassedy (Husband)</b> 886 N. Kensington St. Arlington, Va.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Adenocarcinoma of Rectum with Metastases</b> IMMEDIATE CAUSE (a) DUE TO <b>154 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <del>xxx</del> (this hospital) attended the deceased from <b>3 September 60</b> to <b>22 October 60</b> , that <del>he</del> (we) last saw the deceased alive on <b>22 Oct. 1960</b> , and that death occurred on <b>11:15 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Rexford H. Hunt Jr.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>		22c. DATE SIGNED <b>22 Oct 1960</b>							
22c. PHYSICIAN'S NAME (Type) <b>Rexford H. HUNT LT MC USN</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10-25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>E.E. Hunt</b>				ADDRESS <b>ives Funeral Home, 2847 Wilson Blvd, Arlington Va.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 24 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>							

11578

11578

CENTRAL OF CRYSTAL

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

11578

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>1 mo - less 3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1721 LUZERNE AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANA</u> Middle <u>Edmund</u> Last <u>Cheney</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gas station attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mazzulo Bros.</u>	11. BIRTHPLACE (State or foreign country) <u>NEW Hampshire</u>
13. FATHER'S NAME <u>David O. Cheney</u>		14. MOTHER'S MAIDEN NAME <u>I. Dana</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W. W. I</u>		16. SOCIAL SECURITY NO. <u>002-03-3379</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X Metastatic carcinoma of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Carcinoma of the tail of pancreas</u> (c) <u>6 mos</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute bacterial endocarditis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 9, 1960</u> , to <u>Oct 5, 1960</u> , that I last saw the deceased alive on <u>Oct 5, 1960</u> , and that death occurred at <u>9:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abraham W. Danish</u> M.D.		ADDRESS (Street, city or town, state) <u>927 Beverly Dr. Silver Spring, Md</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		DATE SIGNED <u>10-6-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>DOET 10 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11008

CENTRAL OF GEORGIA

11008

THE STATE OF GEORGIA

11008

THE STATE OF GEORGIA  
COUNTY OF ...  
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

11578

1

MONTGOMERY MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 1, Gaithersburg 12 yrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 1, Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 1, Gaithersburg</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS Solomon Claggett</u>				4. DATE OF DEATH <u>Oct. 16, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>16</u> Hours <u>16</u> Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Claggett</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Florence Claggett, wife</u> Address <u>R.D. 1, Gaithersburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 162.1 DUE TO <u>Left, Lung field</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO <u>—</u> (c) DUE TO <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IN ANITATION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1957</u> to <u>Oct. 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 16, 1960</u> , and that death occurred <u>at 11:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Clive E. Jackson, M.D.</u>		22b. DATE SIGNED <u>Oct. 10, 60</u>		22c. PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>			
22d. ADDRESS <u>R.D. 1, Gaithersburg</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u>		ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Wm. H. Wood

Retired  
Male Negro  
Jan. 4 1883 17  
Md.  
U.S.A.

RE TIED  
Male Medico

Charles Gladett

Left, Grandfield  
Bronchopneumonic  
Gardner, W. F.  
1501

57.4045

*(Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.)*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9-59

1

11579

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11510

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>5 1/2 MRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>CLARKSVILLE</b>			
3. NAME OF DECEASED (Type or print) <b>DONALD</b> First Middle Last				4. DATE OF DEATH <b>COLEMAN</b> Month <b>OCTOBER</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 14, 1960</b>	
9. AGE (In years last birthday) <b>5</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>30</b>		IF UNDER 24 HRS. Hours <b>5</b> Min. <b>30</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>RAYMOND ELWOOD COLEMAN</b>				14. MOTHER'S MAIDEN NAME <b>JEAN ALDA SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>				16. SOCIAL SECURITY NO. <b>HOSPITAL RECORDS, ODNEY, MD.</b>			
17. INFORMANT <b>HOSPITAL RECORDS, ODNEY, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity, Immaturity (2 lbs. 5 ounces)</b> 776X DUE TO (b) <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14, 1960</b> to <b>Oct. 14, 1960</b> that (I) (we) last saw the deceased alive on <b>Oct. 14, 1960</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Jack Schumacher</b> M.D.				22b. DATE SIGNED <b>10.15.60</b>			
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>				22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel.</b>		23d. LOCATION (City, town, or county) (State) <b>Highland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sumrell</b> ADDRESS <b>Rookville, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>	

227321 7XV1

11540

DEPARTMENT OF HEALTH  
CENTRAL RECORDS SECTION

11540

HOWARD

HOWARD

HOWARD

CLARKSVILLE

U.S.D.

U.S.D.

OCTOBER 1960

OCTOBER 1960

OCTOBER 1960

OCTOBER 1960

OCTOBER 1960

OCTOBER 1960

U.S.A.

MARYLAND

JOHN ALBA SMITH

RAYMOND EDWARD COLEMAN

CLNEY, MD.

HOSPITAL RECORDS

*Raymond Edward Coleman*

CLARKSVILLE, MD.

JACK SCHMIDT, M.D.

11580

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11511

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>3 HRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>CLARKSVILLE</b>			
3. NAME OF DECEASED (Type or print) First <b>DOUGLAS</b> Middle Last <b>COLEMAN</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/14/60</b>	
9. AGE (In years lost birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>RAYMOND ELWOOD COLEMAN</b>				14. MOTHER'S MAIDEN NAME <b>JEAN ALDA SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEDICAL RECORDS, OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity, Immaturity (2 lbs. 4 ounces)</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14 1960</b> to <b>Oct. 14 1960</b> that (I) (we) last saw the deceased alive on <b>Oct. 14 1960</b> and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jack Schumacher</b>				22b. DATE SIGNED <b>10.15.60</b>		22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>	
22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>				22e. ADDRESS <b>Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel,</b>	
23d. LOCATION (City, town, or county) <b>Highland, Md.</b>				23e. LOCATION (City, town, or county) _____ (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snodden</b>				25a. REC'D BY REGISTRAR <b>OCT 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2173216XV1

11511

11510

CENTRAL OF DEATH

MONTGOMERY MARYLAND HOWARD

CLARKVILLE E. HRS. LEMAY

WALTERS GENERAL HOSPITAL

OCTOBER 10 COLMAN DOUGLAS

10/14/50 HERR

MARYLAND U. S. A.

LEAH ALMA SMITH HAYWARD ELWOOD COLMAN

HEALTH RECORD, STATE, MD.

*Handwritten signature and notes*

W. J. SCHMIDT, M. D. (RECORDED, MARYLAND)

*Handwritten notes and stamps at the bottom of the page*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Olney</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>c/o Rosa Benson Brown</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>unknown</b> Last <b>Cook</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Rosa Benson Brown</b> Address <b>Sandy Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 14</b> , 19 <b>58</b> , to <b>Oct.</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Oct 14</b> , 19 <b>60</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard A. Yates M.D.</b>		ADDRESS (Street, city or town, state) <b>Olney, Md.</b> DATE SIGNED <b>10-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Richard A. Yates M.D.</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-25-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Flint Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Oakton Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 31 '60</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11582  
11513  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>RED 3, zone 14 Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Boulah Frances</u> <u>COOLEY</u>				4. DATE OF DEATH Month Day Year <u>October 19 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 25 1902</u>		9. AGE (In years last birthday) <u>58</u> YRS.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E Bissett</u>				14. MOTHER'S MAIDEN NAME <u>Nancy W Kitchen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Charles L. Cooley RFD 3, zone 14 Bethesda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>OCT 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>10-17</u> 19 <u>60</u> , and that death occurred at <u>10-19-60</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul D. Cantor MD</u>				22b. DATE SIGNED <u>10-19-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Paul D. Cantor</u>	
22d. ADDRESS <u>4709 Montg. Lane, Bethesda, Md</u>				22e. REC'D BY REGISTRAR <u>OCT 21 '60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 21 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles L. Frank</u>	

11513

CERTIFICATE OF BIRTH

11585

NOT BORN

COOK

11585

11585

11585

AND MORE TIME, HEREIN

Paul D. Gannon

Healyville, Maryland

10/21/00

11585

11585

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11507

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u> <u>16X-2</u>		d. STREET ADDRESS <u>21 Bicket Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ropine Nursing Home</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>I</u> Last <u>Castello</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-85</u>	
9. AGE (in years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Wadsworth, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Nursing Home Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Frank died suddenly</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Frank died suddenly</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschauer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-18-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J Broschauer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

1

Robert A. Pugherty, Bethesda, Maryland  
Burial 10/22/10 Gate of Heaven Co., Silver Spring, Maryland

11583

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11514

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>206 Shaw Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>E.</b> Last <b>COUNSELMAN</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/1879</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none-Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. H. Green</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Coffey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Son</b>		Address <b>Roy Counselman 206 Shaw Ave., Silver Sp., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOSTATIC PNEUMONIA, BILATERAL</b> DUE TO (b) <b>DEBILITATION, MALNUTRITION,</b> DUE TO (c) <b>PYRHO NEPHROSIS, SEPTICEMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE RT. FEMUR 31 JUL. 1960</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 1/2 mos.</b> <b>2 1/2 mos.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>FELL DURING DIZZY SPELL IN KITCHEN AT HOME</b> 20c. TIME OF INJURY Month, Day, Year <b>10 JUL 31 1960</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <b>HOME</b> 20f. (City or town) <b>SILVER SPRING, MD</b> (State) <b>MARYLAND</b> 21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>MAR. 1955</b> to <b>19 OCT. 1960</b> that (I) <b>last</b> saw the deceased alive on <b>19 OCT. 1960</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Marshall Covillier Jr. MD</b> 22c. PHYSICIAN'S NAME (Type) <b>L. MARSHALL COVILLIER JR. MD</b> 22d. ADDRESS <b>1407 WOODSIDE PKWY SILVER SPRING, MARYLAND</b> 22b. DATE SIGNED <b>20 OCT 1960</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/24/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> DATE <b>OCT 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

1151

CERTIFICATE OF DEATH

11583

10/25/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50

11/1/50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11584  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11515

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alta Vista Nursing Home</b>		d. STREET ADDRESS <b>4709 Morgan Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Berdie Hough Crawford</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/1874</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. W. Hough</b>		14. MOTHER'S MAIDEN NAME <b>Jane Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss Jane E. Crawford</b>		<b>4709 Morgan Dr. Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350X</b> DUE TO <b>Coronary Artery Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis with Parkinsonism</b> DUE TO (c) <b>sudden</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Compression Fracture of Lumbar Vertebra 9/27/60</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1954</b> to <b>Oct 27, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Oct 27, 1960</b> , and that death occurred at <b>Oct 27, 1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Have</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Have M.D.</b>		22d. ADDRESS <b>5516 Nebraska Ave. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/1/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. H. Co.</b>		25. REC'D BY REGISTRAR <b>2901-24 St. WASH D.C.</b>	
25a. DATE <b>OCT 31 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	



11522

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11611 Dewey Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Crothers</u> First Middle Last		4. DATE OF DEATH <u>October 8</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1960</u> yrs. - Months - Days - Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Paul David Crothers</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Mae McConnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FATHER</u>		Address <u>Same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/7/60</u> , 19____, to <u>10/8/60</u> , 19____, that I last saw the deceased alive on <u>10/7/60</u> , 19____, and that death occurred at <u>7:35 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. W. Smith</u> M.D. <u>13018 GEORGIA AVE.</u> PHYSICIAN'S NAME (Type) <u>A. W. SMITH</u> <u>WHEATON, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>10-10-60</u>	<u>Washington San &amp; Hospital - TAKOMA PARK, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		24a. REC'D BY REGISTRAR <u>13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11585 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11517  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>olney</b> c. LENGTH OF STAY IN 1b <b>4days 2hurs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>14 Chesnut Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Roberta</b> Last <b>Crown</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 24, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Small</b>		14. MOTHER'S MAIDEN NAME <b>Annie Fleming</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>malignancy of right lung first seen 170X</b> DUE TO <b>malignancy of left breast - first seen</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>170X</b> DUE TO <b>170X</b> (c) <b>170X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9-20-60</b> <b>Oct-26-1960</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct-26-1960</b> to <b>Oct-1-1960</b> , that (I) (we) last saw the deceased alive on <b>Oct-1-1960</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William C. Miller</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William C. Miller</b>		22d. ADDRESS <b>7 Brooks Avenue, Gaithersburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-4-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		25a. REC'D BY REGISTRAR <b>Gaithersburg Md.</b>	
ADDRESS <b>Gaithersburg Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William C. Miller</b>	
DATE <b>OCT 4 '60</b>		DATE <b>OCT 4 '60</b>	

11517

11585

CERTIFICATE OF DEATH

Investigation of left hand - first case Oct 26 1900  
Investigation of right hand - first case p-22-0

Oct-26-02 Oct-1-02  
19

Oct-1-02  
William F. Miller

Proctor Green, Washington, D.C.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11523

## CERTIFICATE OF DEATH

Reg. Dist. No.

14560

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>Route 3, Box 141-B</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Infant</u> First Middle Last <u>Culbertson</u>		<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>31</u> Year <u>1960</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-31-60</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>—</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> <b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>13. FATHER'S NAME</b> <u>Paul Trauger Culbertson, Jr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ruth Juanita Whitley</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mother's Chart</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia due to pulmonary hypoplasia</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac interventricular membranous septal defect.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>12401</u>			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>10-31</u> , 19 <u>60</u> , to <u>10-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-31</u> , 19 <u>60</u> , and that death occurred at <u>2:45 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
<b>ACTUAL SIGNATURE</b> <u>Charles R. Hughes</u>		<b>M.D.</b> <u>911 Silver Spring Ave., Silver Spring, Md.</u>					
<b>PHYSICIAN'S NAME (Type)</b> <u>Charles R. Hughes, M. D.</u>		<u>same as above</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>22b. DATE THEREOF</b> <u>10-31-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Hare, M. D.</u>		<b>ADDRESS</b> <u>Washington Sanitarium &amp; Hospital</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 8 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

2075293XV2

CERTIFICATE OF DEATH

Form No. 10

1917

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTIC

NAME OF LABORATORY

NAME OF PATHOLOGIST

NAME OF BACTERIOLOGIST

NAME OF VETERINARIAN

NAME OF JUDGE

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTIC

NAME OF LABORATORY

NAME OF PATHOLOGIST

NAME OF BACTERIOLOGIST

NAME OF VETERINARIAN

NAME OF JUDGE

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTIC

NAME OF LABORATORY

NAME OF PATHOLOGIST

NAME OF BACTERIOLOGIST

NAME OF VETERINARIAN

NAME OF JUDGE

NAME OF CLERK

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

11524  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11518  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ad. West Hyattsville</u> d. STREET ADDRESS <u>16521 Lewisdale Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>James Bernard Curtin</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1960</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <u>2-4-1918</u>		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles O. Curtin</u>		14. MOTHER'S MAIDEN NAME <u>Anna Meikel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army 40-45</u>		16. SOCIAL SECURITY NO. <u>420-1</u>	
17. INFORMANT <u>Mrs. Doris Curtin</u>		Address <u></u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart attacks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		20c. TIME OF INJURY Month, Day, Year <u>10 30 1960</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR <u>Halley's Funeral Home, Inc.</u>		ADDRESS <u>McLain, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

MEDICAL CERTIFICATION

2

BB

MASTLAND STATE DEPARTMENT OF HEALTH

STATE OF MASTLAND DEPARTMENT OF HEALTH

11211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11211

FOR STATE

MASTLAND DEPARTMENT OF HEALTH

1

700-2000

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11519

11505

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>3 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1706 GRIDLEY LANE</b>				d. STREET ADDRESS <b>1706 GRIDLEY LANE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FRANCIS</b> Last <b>DALTON, SR</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/8/79</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Municipal Architect</b>		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PATRICK DALTON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZA GREY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>678-32-6962</b>		17. INFORMANT <b>Mrs. Mary E. Dalton, 1706 Gridley Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1961</b> to <b>Oct. 6 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 6 1960</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Abraham W. D. Davis</b>				22b. DATE SIGNED <b>10-7-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DAVIS</b>				22d. ADDRESS <b>927 Passapatanz Dr. Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11519

STATE OF NEW YORK

11507

IN SENATE,  
January 1, 1903.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1902.  
ALBANY:  
J. B. LEECH, PRINTER.  
1903.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11586 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11520

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>N.J.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (if inside corporate limits, write RURAL and give nearest town) <u>River Edge</u>		d. STREET ADDRESS <u>184 Oxford Ter.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11419 Neopot mill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eloise Marie Daly</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ila.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>Pierce</u>		17. INFORMANT <u>Muchar Daly - Stein</u> Address <u>Powam</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-19-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>10/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hackensack, Bergen County, N.J.</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

2

11550

11550

11550

11550

11550

11550

11550

11587

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11521

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>6007 Namekagan Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Norman Francis Denis</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 7, 1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	
11. BIRTHPLACE (State or foreign country) <b>Woonsocket, Rhode Is.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Denis</b>		14. MOTHER'S MAIDEN NAME <b>Ursula Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>377-09-3033</b>	
17. INFORMANT <b>Norma Denis</b>		Address <b>6 Russell Rd. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6:30 AM 10-28-1960</b> to <b>11:20 AM 10-28-1960</b> , that (I) (we) last saw the deceased alive on <b>10-28-1960</b> , and that death occurred at <b>11:20 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward Lewis, Jr. MD</b>		22b. DATE SIGNED <b>NOV 2 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD LEWIS, JR. MD</b>		22d. ADDRESS <b>5800 PEECH AVE. BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2 Nov 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeVol Funeral Home</b>		25a. REC'D. BY REGISTRAR <b>NOV 2 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11081

CERTIFICATE OF DEATH

11081

FOR HEALTH

death. If any delay is necessary, send 3 to the funeral director. Page 9 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. P

VS. A15.  
SM 7/1

STATE  
DEPT  
M  
075  
I  
MEDICAL CERTIFICATION  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2 with the State Board of Health 2 weeks after death.  
or its designated agent, prior to burial, cremation, or removal, and in any event within 39

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11525

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11522

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park Md.</b> c. LENGTH OF STAY IN 1b <b>2 1/2 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington San + Hosp.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>DC</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington DC</b> d. STREET ADDRESS <b>648 9th St. NE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF CEASED (or print) <b>Corrine NMN Daugett</b>			4. DATE OF DEATH <b>10-26-1960</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-26-34</b>	9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Domestic</b>			11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Beason</b>			14. MOTHER'S MAIDEN NAME <b>Lillie M. McCoy</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>577-48-0500</b>		
17. INFORMANT <b>Bertha Mae McCoy</b>			Address <b>648 9th St. NE DC</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>434 J</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschant</b>		M.D. <b>FRANK J. Broschant</b>		DATE SIGNED <b>10-26-60</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)	
<b>Burial</b>	<b>11/1/60</b>	<b>Woodlawn Cemetery</b>	<b>Washington</b>	<b>D.C.</b>	
Funeral Director		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>Funeral Home 412 H St. N.E.</b>		<b>Washington D.C.</b>		<b>OCT 31 '60</b>	<b>Arthur S. Thomas</b>

Washington D.C. By E. J. Murray 495





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11523

11528

Item 8 Film 275 10-21-60 et

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tokoma Park</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>8209 14th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Romeo Etienne David</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>1960</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1882</b>		9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hull, Quebec, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		13. FATHER'S NAME <b>Stephan David</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eunice E. Coxon</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIOCLEROTIC HT DIS EDSO</b> DUE TO (c) <b>GENERALIZED ARTERIOCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b> <b>3 YEARS</b> <b>7-8 YRS.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20</b> 19 <b>60</b> , to <b>OCT 12</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> 19 <b>60</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Harold Sterling M.D.</b>		22b. ADDRESS <b>1352 UNIVERSITY BLVD. HYATTSVILLE, MD.</b>		22c. PHYSICIAN'S NAME (Type) <b>Harold Sterling M.D.</b>		22d. DATE SIGNED <b>OCT 12 - 1960</b>		22e. DATE SIGNED <b>OCT 12 - 1960</b>		22f. DATE SIGNED <b>OCT 12 - 1960</b>		22g. DATE SIGNED <b>OCT 12 - 1960</b>		22h. DATE SIGNED <b>OCT 12 - 1960</b>		22i. DATE SIGNED <b>OCT 12 - 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Pasch's Sons</b>		ADDRESS <b>4735 Baltimore Ave. Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

11523

OFFICE OF THE

11523

1

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11547  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
11524

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase Greenvale Str</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2915 Greenvale Street</b>				d. STREET ADDRESS <b>2915 Greenvale Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>K</b> Last <b>Delp</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/1/1909</b>	
9. AGE (in years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dewain L Delp-Husband-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>420-1</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>10-3-60</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Silver Spring, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Robert A. Pumphrey Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

11324

11324

Portsmouth

Marjorie

Monroe

Gray Case

11324

11324

11324

11324

11324

11324

11324

11324

11324

11324

11324

11324

11324

11324

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11588

11525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>4 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>8511 West Howell Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Helen</b> First <b>B</b> Middle <b>Deoudes</b> Last		4. DATE OF DEATH Month <b>Oct.</b> Day <b>22</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/26</b>
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Angelos H. Bacas</b>		14. MOTHER'S MAIDEN NAME <b>Doula A. Metrakos</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Hospital record.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Herniation of brain stem</b> <b>825X</b> DUE TO (b) <b>Irreversible shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Massive hemorrhage</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of humerus - Crushed chest - rt.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was passenger in car involved in auto accident.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:50</b> Hour <b>9</b> m. <b>A</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) (County) (State) <b>Bethesda Montg. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		DATE SIGNED <b>9/23/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>Washington, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>Curtis L. Kraus</b>		DATE <b>OCT 25 '60</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

1188

1188

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. Key sections include:

- Section 1: Patient Information (Name, Age, Sex, Race, etc.)
- Section 2: Medical History (Previous illnesses, habits, etc.)
- Section 3: Examination Findings (Vital signs, physical exam, etc.)
- Section 4: Cause of Death (Immediate and underlying causes)
- Section 5: Signature and Date of Examiner

The form is filled out with handwritten text, which is difficult to read due to the orientation and image quality. The text appears to be a medical report for a patient, likely from the early 20th century.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11589

11526

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Shawn</b> Middle <b>Michael</b> Last <b>DIVINE</b>				4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29-60</b>	9. AGE (In years last birthday) yrs. <b>7</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>Min.</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland St. Mary's Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert John DIVINE</b>				14. MOTHER'S MAIDEN NAME <b>Diana Jeanne BEARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) Robt. J. Divine, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>759.3</b> DUE TO <b>Congenital Malformation, urinary system, &amp; bilat. hydronephrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital malformation possibly of lung and possibly of heart</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <b>Sept. 30 1960</b> to <b>Oct. 6 1960</b> , that (I) <b>xx</b> lost saw the deceased alive on <b>Oct. 6 1960</b> , and that death occurred at <b>12:05 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence G. Thorne</b>				22b. DATE SIGNED <b>10-7-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence G. THORNE, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>10-7-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Columbus Ohio</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

2051201XV5

11589

11589

CENTRAL CHINA

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

11527

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>German Town, Maryland</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES DANIEL DORSEY</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 17 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-1893</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>3 21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen'l. Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>German Town, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bradley Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Ella Mae Slagle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Margaret F. Dorsey - German town, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremic poisoning</b> DUE TO <b>metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Colorectal carcinoma of Prostate</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>16 months</b> <b>16 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>January, 1950</b> , to <b>Oct 16, 1960</b> , that I last saw the deceased alive on <b>Oct 16, 1960</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Fawcett, M.D.</b>		ADDRESS (Street, city or town, state) <b>Dawsonville, Md</b> DATE SIGNED <b>10-17-60</b>	
PHYSICIAN'S NAME (Type) <b>John G. Fawcett, M.D.</b>		<b>Dawsonville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-19-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Neelsville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mont. County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith Tarter</b>		24a. REC'D BY REGISTRAR <b>316 E. Diamond Ave., Gaithersburg, Md.</b> DATE <b>OCT 19 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md</i> c. LENGTH OF STAY IN 1b <i>one year</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Sara</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md</i> d. STREET ADDRESS <i>111, 119 Colesville Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>DAVID</i> Middle <i>H.</i> Last <i>DOSIK</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wht</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-25-06</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>
13. FATHER'S NAME <i>Samuel Dosik</i>		14. MOTHER'S MAIDEN NAME <i>ANNA BLOOM</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>420.1</i> DUE TO <i>Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } DUE TO <i>Myocardial Infarction.</i> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1960</i> to <i>Oct 1960</i> that (I) (we) last saw the deceased alive on <i>10-11 1960</i> , and that death occurred on <i>12:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert Kramer</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT KRAMER, M.D.</i>		22d. ADDRESS <i>1703 East-West Highway.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>10-12-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEMORIAL GARDEN - FALLS CHURCH. VA.</i>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danzansky</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 13 '60</i>	
ADDRESS <i>3501-14 St. N. W.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

11588

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-15-01 BY 60322 UCBAW

11588



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "BANK" and "1-2-6" are visible.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11529  
M  
073  
1  
0  
1  
BB

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 1 HR. 15 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARA Roper---- DOVE		4. DATE OF DEATH Month Day Year OCTOBER 26, 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-8-1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WASHINGTON ALBERT ROPER		14. MOTHER'S MAIDEN NAME MARY CATHERINE HEDGES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Heart Failure. DUE TO (b) C. V. A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 19 57 to Oct 26, 19 60 that (I) (we) last saw the deceased alive on Oct 26, 19 60, and that death occurred at 4:15 AM from the causes and on the date stated above.			
22a. SIGNATURE L. I. LEAL, M. D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-60	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

11539

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
INVESTIGATION OF DEATH

11539

NAME

AGE

RESIDENCE

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

INVESTIGATOR

REPORT

DATE

TIME

PLACE

CAUSE

MANNER

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
X  
I  
O

11592

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11530

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>				c. LENGTH OF STAY IN 1b <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emory Grove Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>DYSON</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1898</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Zackariah Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Howard Dyson Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Rheumatoid Arthritis</u> DUE TO (c) <u>Myocarditis, Chronic.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>about 15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> 19 <u>  </u> to <u>Oct 2</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>60</u> , and that death occurred at <u>  </u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Luciano I. Leal</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>				22d. ADDRESS <u>Gaithersburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11531

11593

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium &amp; Hospital</b>			d. STREET ADDRESS <b>3505 Thormapple Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN BUCKINGHAM ENGLISH</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>16</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1878</b>		9. AGE (In years last birthday) <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
13. FATHER'S NAME <b>Thom as English</b>			14. MOTHER'S MAIDEN NAME <b>? Jones</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Carl M English-son-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Failure</b> DUE TO (c) <b>Myocarditis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 d.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10-15</b>	
20f. (City or town) <b>Rockville, Maryland</b>		20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1958</b> to <b>Oct 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>10-15</b> 1960, and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>William Fleet Luckett</b>		22b. DATE SIGNED <b>10-16-60</b>		22c. PHYSICIAN'S NAME (Type) <b>William Fleet Luckett</b>	
22d. ADDRESS <b>5000 Reno Road, N. W., Wash. D. C.</b>		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		25c. (State)			

11537

CERTIFICATE OF DEATH

11537



Montgomery  
Business  
James Buchanan & Hospital  
JOHN BUKI  
Male  
White  
Butcher-Resident  
Thomson  
No

Garfield  
Van  
No

Willie Mae Jackson  
2000 Bond Road  
Rockwell, Maryland  
Robert A. Jackson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11532

11528

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>		d. STREET ADDRESS <u>700 Madison Street, Apt. 201</u>	
3. NAME OF DECEASED (Type or print) First <u>(Infant)</u> Middle <u>Errigo</u> Last <u>Errigo</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-60</u>
9. AGE (In years last birthday) yrs. <u>13</u> Min. <u>42</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u>42</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paolo (NMN) Errigo</u>		14. MOTHER'S MAIDEN NAME <u>Grace (NMN) Errigo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia.</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature separation of placenta.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Winston E. Cochran</u>		M.D. <u>927 Pershing Dr., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M. D.</u>		<u>927 Pershing Dr., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital, Takoma Park, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D.</u>		ADDRESS <u>Washington Sanitarium and Hospital, 60</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Hare</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

CERTIFICATE OF DEATH

11533

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. NAME OF REGISTRAR</p> <p>21. NAME OF WITNESSES</p> <p>22. NAME OF DECEASED</p>
---	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11594  
11533  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>30 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Irene</b> Last <b>Essex</b>		4. DATE OF DEATH Month <b>10/</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/82</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher Columbus Murphy</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE Vathen Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Evelyn E. Mills</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 4</b> 19 <b>60</b> , to <b>Oct 6</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 6</b> 19 <b>60</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe</b>		22b. DATE SIGNED <b>Oct 6 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe</b>		22d. ADDRESS <b>10511 Summit Dr. Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 11 '60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

11538

CERTIFICATE OF DEATH

11534



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9-59

1  
11595  
MONTGOMERY  
OLNEY  
13 DAYS  
MONTGOMERY GENERAL HOSPITAL  
DUANE LEE FINK  
MALE WHITE  
WIDOWED DIVORCED  
OCTOBER 6, 1960  
Olney, Maryland  
U.S.A.  
HOSPITAL RECORDS, OLNEY, MARYLAND  
Bilateral Bronchopneumonia  
Prematurity and Immaturity  
CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  
10-6-1960 to 10-19-1960  
12:05 PM  
A. D. BONIFANT, M. D.  
SANDY SPRING, MARYLAND  
Burial 10-19-60 St. Luke Redland, Md.  
Francis X. Barber Laytonsville, Md.  
2173364 XV 0  
NOV 2 '60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11534

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DUANE Middle LEE Last FINK		4. DATE OF DEATH Month OCTOBER Day 19, Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6, 1960
9. AGE (In years lost birthday) yrs. 13		10. IF UNDER 1 YEAR Months 13 Days 13 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Olney, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND AUSTIN FINK		14. MOTHER'S MAIDEN NAME MARGRETTA BARBER SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 783.5 DUE TO Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity and Immaturity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-6-1960 to 10-19-1960, that (I) (we) lost saw the deceased alive on 10-19-1960, and that death occurred at 12:05 PM, from the causes and on the date stated above.			
22a. SIGNATURE A. D. BONIFANT, M. D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-60	
23c. NAME OF CEMETERY OR CREMATORY St. Luke		23d. LOCATION (City, town, or county) (State) Redland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis X. Barber		25a. REC'D BY REGISTRAR	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE	
DATE NOV 2 '60			

11593

CERTIFICATE OF DEATH

11593

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF REGISTRAR

*Handwritten signature*

1-10-10  
1-10-10  
1-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
15M 9/59

1

M

073

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11596

11535

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>9 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>R-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DWIGHT</b> Middle <b>LEE</b> Last <b>FINK</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 6, 1960</b>
9. AGE (In years last birthday) yrs. <b>9</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min. <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RAYMOND AUSTION FINK</b>		14. MOTHER'S MAIDEN NAME <b>MARGRETTA BARBER SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MOTHER - HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis bilateral</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity (6months gestation)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> 19 <b>60</b> to <b>10/6</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/6</b> 19 <b>60</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED <b>10-7-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-7-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's</b>		23d. LOCATION (City, town, or county) (State) <b>Redland Mont. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Francis H. Barber</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>OCT 11 '60</b>	

2273365xv0

11535

11535

CERTIFICATE OF DEATH

Matyland

Funeral Home  
11535  
11535

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>and Va</u> b. COUNTY <u>and Loudoun</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lincoln (rural)</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13005 Parkland Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ambrey Flynn</u>		4. DATE OF DEATH <u>Oct 17 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-1886</u>
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Va. (Fauquier Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Flynn</u>		14. MOTHER'S MAIDEN NAME <u>Julia Flynn Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Anna Laurie Flynn (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Lincoln, Virginia</u>	
23. FUNERAL DIRECTOR <u>Hall Funeral Home - Purcellville, Va.</u>		24. REC'D BY REGISTRAR <u>Alice C. Hall</u>	
24b. REGISTRAR'S SIGNATURE <u>Alice C. Hall</u>		DATE <u>OCT 19 '60</u>	

MEDICAL CERTIFICATION

2

11536

11537

FOR SALE

WATER BOTT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11598  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11537

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>111 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Johnstown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Johnstown</b> d. STREET ADDRESS <b>731 Smith Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>(None)</b> Last <b>Fogel</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1951</b>
9. AGE (In years last birthday) <b>9</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>X</b> Min. <b>3</b>	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>5</b> Hours <b>X</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward J. Fogel</b>		14. MOTHER'S MAIDEN NAME <b>Ann Karlik</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute lymphatic leukemia</b> DUE TO <b>204-3</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>June 13, 1960</b> to <b>October 2, 1960</b> , that (we) last saw the deceased alive on <b>October 2, 1960</b> , and that death occurred at <b>8:30AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jerome B. Block M.D.</b>		22b. DATE SIGNED <b>10/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerome B. Block, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-5-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST PETER + PAUL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>JOHNSTOWN CAMBRIA COUNTY, PA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers Co. 1400 Chapin St</b>		25a. REC'D BY REGISTRAR <b>OCT 6 '60</b>	
ADDRESS <b>1400 Chapin St</b>		25b. REGISTRAR'S SIGNATURE <b>Clifton S. Kline</b>	

11532

11531

CONTINUATION OF DATA

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

DATE OF BIRTH  
PLACE OF BIRTH

FATHER'S NAME  
MOTHER'S NAME

DATE OF DEATH  
PLACE OF DEATH

THE FOLLOWING TABLES SHOW THE DEATHS OF WHITE MALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911

THE FOLLOWING TABLES SHOW THE DEATHS OF WHITE FEMALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911

THE FOLLOWING TABLES SHOW THE DEATHS OF COLORED MALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911

THE FOLLOWING TABLES SHOW THE DEATHS OF COLORED FEMALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911

THE FOLLOWING TABLES SHOW THE DEATHS OF WHITE MALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911

THE FOLLOWING TABLES SHOW THE DEATHS OF WHITE FEMALES

AGED 15 YEARS AND OVER IN THE CITY OF BOSTON

FOR THE YEAR 1911



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11599

CERTIFICATE OF DEATH

11538

Item 21 Film 0273 10-21-60 et

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>36 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2431 Newton Street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ennis</b> Middle <b>Lee</b> Last <b>Ford</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 23, 1889</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apartment House Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ford</b>		14. MOTHER'S MAIDEN NAME <b>Indiana Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-097454</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>Unascertainable The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 8, 1960</b> to <b>October 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 14, 1960</b> , and that death occurred on <b>Oct. 14, 1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward E. Morse</b> M.D.		22b. DATE <b>10/14/60</b> SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Edward E. Morse, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore 14, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b> ADDRESS <b>622 York Road Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 19 '60</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

2031

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>08 Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>Goshen Rd. R - 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>Franklin</u> Last <u>Franklin</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1900</u>
9. AGE (in years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ermatian Furlow</u>	
17. INFORMANT <u>Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>Rockville</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>
DATE <u>OCT 31 '60</u>			

MEDICAL CERTIFICATION

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Manner of death: [illegible]  
6. Signature of physician: [illegible]  
7. Signature of medical examiner: [illegible]  
8. Date of report: [illegible]

1. Name of deceased: [illegible]		2. Date of death: [illegible]	
3. Place of death: [illegible]		4. Cause of death: [illegible]	
5. Manner of death: [illegible]		6. Signature of physician: [illegible]	
7. Signature of medical examiner: [illegible]		8. Date of report: [illegible]	
9. Remarks: [illegible]			
10. [illegible]			
11. [illegible]			
12. [illegible]			
13. [illegible]			
14. [illegible]			
15. [illegible]			
16. [illegible]			
17. [illegible]			
18. [illegible]			
19. [illegible]			
20. [illegible]			
21. [illegible]			
22. [illegible]			
23. [illegible]			
24. [illegible]			
25. [illegible]			
26. [illegible]			
27. [illegible]			
28. [illegible]			
29. [illegible]			
30. [illegible]			
31. [illegible]			
32. [illegible]			
33. [illegible]			
34. [illegible]			
35. [illegible]			
36. [illegible]			
37. [illegible]			
38. [illegible]			
39. [illegible]			
40. [illegible]			
41. [illegible]			
42. [illegible]			
43. [illegible]			
44. [illegible]			
45. [illegible]			
46. [illegible]			
47. [illegible]			
48. [illegible]			
49. [illegible]			
50. [illegible]			
51. [illegible]			
52. [illegible]			
53. [illegible]			
54. [illegible]			
55. [illegible]			
56. [illegible]			
57. [illegible]			
58. [illegible]			
59. [illegible]			
60. [illegible]			
61. [illegible]			
62. [illegible]			
63. [illegible]			
64. [illegible]			
65. [illegible]			
66. [illegible]			
67. [illegible]			
68. [illegible]			
69. [illegible]			
70. [illegible]			
71. [illegible]			
72. [illegible]			
73. [illegible]			
74. [illegible]			
75. [illegible]			
76. [illegible]			
77. [illegible]			
78. [illegible]			
79. [illegible]			
80. [illegible]			
81. [illegible]			
82. [illegible]			
83. [illegible]			
84. [illegible]			
85. [illegible]			
86. [illegible]			
87. [illegible]			
88. [illegible]			
89. [illegible]			
90. [illegible]			
91. [illegible]			
92. [illegible]			
93. [illegible]			
94. [illegible]			
95. [illegible]			
96. [illegible]			
97. [illegible]			
98. [illegible]			
99. [illegible]			
100. [illegible]			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

11529

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11540

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 1/2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>26</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>1507 East West Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha L. Lena Gainey</u>				4. DATE OF DEATH <u>October 24 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John L. O'Berry</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Washington Sanitarium and Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X PONTINE HEMORRHAGE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 23</u> <u>1960</u> , to <u>OCT. 24</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>OCT. 24</u> <u>1960</u> , and that death occurred at <u>4:19</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u>				22b. DATE SIGNED <u>10/24/60</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>	
				22d. ADDRESS <u>8907 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond L. Ziska</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

11510

11511

RECEIVED

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511

11510

11511



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 6 Film 6274 11-2-60 et

11530

11541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>47X-2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hospital</u>		d. STREET ADDRESS <u>423 Upshur St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Benjamin (nmn) Gatter</u>		4. DATE OF DEATH Month Day Year <u>10 25 1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-80</u>
9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Leon Gatter</u>		14. MOTHER'S MAIDEN NAME <u>Anna Machelik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital Chart.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal insufficiency</u> DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Carcinoma of larynx</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>30 days</u> <u>8 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Craniotomy and nerve root section for pain relief 9/26/60</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/21, 1960</u> to <u>9/24, 1960</u> , that (I) (we) last saw the deceased alive on <u>9/24, 1960</u> and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John T. Lord M.D.</u>		22b. DATE SIGNED <u>10/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord, M.D.</u>		22d. ADDRESS <u>1015 Spring St. Silver Sp. Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ect-v6-60, Chrontograd Ave</u>		23b. DATE THEREOF <u>10/25/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington DC</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B Danyausky</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>OCT 28 '60</u>	

11591

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

11591

11591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

Dr. Brochart Notified

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11601					11542				
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 20 Mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban					d. STREET ADDRESS 3721 Warren St. N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES HENRY GERNER					4. DATE OF DEATH Oct. 31 19 60		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/7/1891		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Gerner					14. MOTHER'S MAIDEN NAME Louise E. Ri ese				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army					16. SOCIAL SECURITY NO.		17. INFORMANT Brother Ernest Gerner Same as Above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1950 to present, that (I) (we) last saw the deceased alive on 10-31-1960, and that death occurred at 56A, from the causes and on the date stated above.									
22a. SIGNATURE CP Ryland					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-31-60		
22c. PHYSICIAN'S NAME (Type) Charles P. Ryland					22d. ADDRESS 4400-49 St NW Washington DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov 3 1960		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Wash. DC		
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home					ADDRESS 4812 Gt. Ave NW		25a. REC'D BY REGISTRAR DATE NOV 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard

11513

CERTIFICATE OF DEATH

11601

RECEIVED  
FEB 11 1961  
U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C. 20540

## CERTIFICATE OF DEATH

11543  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHEATON NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BESSIE — GINSBURG</b>		4. DATE OF DEATH Month Day Year <b>OCT. 4- 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MORRIS WHITMAN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MORRIS GINSBURG</b>		Address <b>1701-SCAMORE NW DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X Branchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 sak</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>may 19 49</b> to <b>Oct 4 1960</b> that I lost s/he the deceased alive on <b>Oct 3 1960</b> , and that death occurred at <b>4:45 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence J. Thomas</b> M.D.		ADDRESS (Street, city or town, state) <b>900 17th St N.W. - WASH, D.C. 90/4/60</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE J. THOMAS</b>		DATE SIGNED <b>9/4/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM JEM CAP HTS., MD</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gooding Funeral Home</b>		ADDRESS <b>4217-9th NW</b>	
24a. REC'D BY REGISTRAR <b>OCT 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11547

CERTIFICATE OF DEATH

11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500

11500  
11500



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

(M)

X

1

0

15

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11544											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				c. LENGTH OF STAY IN 1b <i>D.O.A.</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>B+O RR near 1550 Rockville Pike</i>				d. STREET ADDRESS <i>13002 Atlantic Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>PAUL MICHAEL GRANT</i>				Last First Middle				4. DATE OF DEATH <i>October 25, 1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/25/48</i>		9. AGE (In years last birthday) <i>11</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Paul F. Grant</i>				14. MOTHER'S MAIDEN NAME <i>Marguerite F. Bohn</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>-----</i>				17. INFORMANT <i>Paul F Grant-Item# 2</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage &amp; laceration</i> DUE TO (b) <i>Compound fracture of skull</i> DUE TO (c) <i>Head partially decapitated</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by train</i>							
20c. TIME OF INJURY Month, Day, Year <i>5:25 a.m. 10-25 1960</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>B+O RR</i>		20f. (City or town) <i>Rockville Montg</i> (County) <i>md</i> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Bloesch</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>10-25-60</i>			
EXAMINER'S NAME (Type) <i>FRANK J. BLOESCH</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/28/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town, or country) <i>Arlington, Virginia</i> (State)					
23. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i> ADDRESS <i>1331 E. Montg. Ave., Rockville, Md.</i>						24a. REC'D BY REGISTRAR <i>OCT 27 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

11558

11558

11558

1

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11602  
11545  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route # 5, Box 183</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Bonnie</b> Middle <b>Elizabeth</b> Last <b>Green</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13, 1950</b>			
9. AGE (In years last birthday) <b>10</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.		IF UNDER 24 HRS. Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Charles W. Green, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Preston</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Lymphatic leukemia</b> 204.3 DUE TO (b) <b>204.3</b> DUE TO (c) <b>204.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 30, 1960</b> to <b>October 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 11, 1960</b> , and that death occurred at <b>7:15 AM</b> on the causes and on the date stated above.									
22a. SIGNATURE <b>Edward E. Morse</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>10/11/60</b>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Edward E. Morse, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 14, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home</b> By <b>Manager</b>				ADDRESS <b>Fairfax, Virginia</b>		25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>			
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>			



• • • • •

100

1111

100

1991-1992, 2000-2001

The Clinical Center, Bethesda, MD.

55

0951, El. 1100.

of

22

• • •

• • •

• • • • •

no. 1111

The Clinical Center, Bethesda, Maryland

Auto Lyndell's Janesville

112:9

65. II related?

6677

INSTITUTE OF HEALTH, HARVARD MEDICAL SCHOOL  
THE CLINICAL CENTER, MEDICAL

• M. D. •

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 11603  
 CERTIFICATE OF DEATH

Reg. Dist. 11546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. LENGTH OF STAY IN 1b <u>02</u> <u>Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26550 Ridge Rd.</u>				d. STREET ADDRESS <u>1 26550 Ridge Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Elizabeth</u> Last <u>Grimes</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1883</u>		9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lyddard</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Lyddard Hobbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT Address <u>Mr. Glenn W. Grimes, Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Occlusion</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>  <u>1959</u>  <u>??</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, severe; cataracts</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>Oct. 22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>60</u> , and that death occurred at <u>6:25 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Meadows</u> M.D.				ADDRESS (Street, city or town, state) <u>Main Street</u>		DATE SIGNED <u>Oct 22 1960</u>	
PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadows, M.D.</u>				LOCATION (City, town, or county) (State) <u>Damascus, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upper Seneca Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Moleman</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

BP

11607

CENTRAL OF OMAHA

11607

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



**UNITED STATES DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11604

11547

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>35 Days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Landon School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robertson</u> Middle <u>Grissold</u> Last <u>JR.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/20</u>		9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landon School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robertson</u>			14. MOTHER'S MAIDEN NAME <u>Abbie Roberts</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Stoan Grissold</u> Address <u>Beth-3, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pericarditis</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophago pericardial fistula</u> DUE TO (c) <u>Carcinoma of Esophagus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Manth, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 15, 1960</u> to <u>October 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 31, 1960</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Tuohy</u>				22b. DATE SIGNED <u>10/31/60</u>		22c. PHYSICIAN'S NAME (Type) <u>John H. Tuohy</u>	
22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <u>NOV 2 '60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/1/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tuckner</u> ADDRESS <u>Beth-17, Md.</u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>NOV 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

1154

CERTIFICATE OF DEATH

11704

1154-11704

SA [illegible]  
[illegible]  
[illegible]

1154-11704

1154-11704

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11550

CERTIFICATE OF DEATH

11548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montg.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>10Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hewitt</b> Middle <b>Duwall</b> Last <b>Grove</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 27-1879</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired R.R. Conductor.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Grove</b>		14. MOTHER'S MAIDEN NAME <b>Susan Duwall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs Josephine Pullian.</b> Address <b>210. Hutton St Gaithersburg. Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>422.2</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Multiple Myeloma.</b> (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years.</b> <b>2 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>1957</b> , 19 <b></b> , to <b>10/14</b> , <b>1960</b> , that I last saw the deceased alive on <b>Oct 10</b> , 19 <b>60</b> , and that death occurred at <b>5 A M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Luciano L. Leal</b> M.D.		ADDRESS (Street, city, or town, state) <b>Gaithersburg, Md</b> DATE SIGNED <b></b>	
PHYSICIAN'S NAME (Type) <b>Luciano L. Leal</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-14-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Elwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shepherdstown. W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 17 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

1150

1150

TO THE  
HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D.C.

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

11605

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11549

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>37 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Markleysburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Markleysburg</b> d. STREET ADDRESS <b>RD #1, Box 17</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Harry</b>		First <b>Harry</b>		Middle <b>GUTHRIE</b>		Last <b>GUTHRIE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-34</b>		9. AGE (In years last birthday) <b>26</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corp</b>				11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Junior GUTHRIE</b>						14. MOTHER'S MAIDEN NAME <b>Gladys COLE</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>180-26-4548</b>		17. INFORMANT <b>(W) Mrs. Irene E. Guthrie, same as #2 above</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widespread hemorrhage, gastrointestinal, genito-urinary and pulmonary</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>APLASTIC ANEMIA</b> (c) <b>6 WEEKS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>6 WEEKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Markleysburg</b> (County) <b>Pa.</b> (State) <b>Pa.</b>					
21. I certify that (I) <b>Russell Miller, LT (MC) USN</b> attended the deceased from <b>August 29 1960</b> to <b>October 5 1960</b> , that (I) <b>xx</b> last saw the deceased alive on <b>October 5 1960</b> , and that death occurred at <b>10:43 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Russell Miller, LT (MC) USN</b> 22b. DATE SIGNED <b>10-6-60</b>													
22c. PHYSICIAN'S NAME (Type) <b>Russell MILLER, LT, MC, USN</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				23b. DATE THEREOF <b>10-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thomas Cemetery</b>				23d. LOCATION (City, town, or county) <b>Markleysburg Pa.</b> (State) <b>Pa.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b> <b>W. W. Chambers Co., 1400 Chapin St., NW, WashDC</b>						25a. REC'D BY REGISTRAR <b>DATE OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>					

11549

11505

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John G. Guffey		10-10-44	
Age		30	
Sex		Male	
Race		White	
Marital Status		Single	
Place of Birth		U.S.A.	
Usual Residence		U.S. Marine Corp	
Cause of Death		Gutrotic	
Place of Death		U.S. Naval Hospital	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Funeral Home		[Signature]	
Signature of Cemetery		[Signature]	
Signature of Burial Society		[Signature]	
Signature of Burial Association		[Signature]	
Signature of Burial League		[Signature]	
Signature of Burial Club		[Signature]	
Signature of Burial Order		[Signature]	
Signature of Burial Society		[Signature]	
Signature of Burial Association		[Signature]	
Signature of Burial League		[Signature]	
Signature of Burial Club		[Signature]	
Signature of Burial Order		[Signature]	



11531

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11550

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
c. LENGTH OF STAY IN 1b <u>4 months 26 days</u>				d. STREET ADDRESS <u>4314 8th STREET, N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Austin</u> Middle <u>Lamont</u> Last <u>Haggerty</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1873</u>	
9. AGE (In years last birthday) <u>87 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>18</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore Haggerty</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lamont</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Washington Sanitarium and Hospital</u>			
17. INFORMANT Address <u>Washington Sanitarium and Hospital</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Failure</u> 151X DUE TO (b) <u>Carcinoma of Stomach @ Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Pelvis Lumbosacral Rt. Marfan's</u> INTERVAL BETWEEN ONSET AND DEATH <u>Since April 18, 1960</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerotic C.V. Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1960</u> to <u>Oct. 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 30, 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Eanet M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10-31-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL EANET M.D.</u>				22d. ADDRESS <u>6727-16th St. N.W. Wash.</u>			
23a. BURIAL INFORMATION REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>11/2/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town, or county) <u>Oakland, New Jersey</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W., Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>NOV 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

(M)

075

(I)

MEDICAL CERTIFICATION

11520

11521

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

11606

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11551

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8227 Wisconsin Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maxx Mary</b> Middle <b>Louise</b> Last <b>Hand</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1905</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Charles W. Archer</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Gray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>James Hand-Husband-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b> DUE TO <b>arteriosclerotic heart disease</b> (c) <b>3 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>exogenous obesity</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1957</b> to <b>Oct 1960</b> that (I) (we) last saw the deceased alive on <b>Oct 21 1960</b> and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilfred R. Ehrmantant</b> M.D.		22b. DATE SIGNED <b>10/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantant M.D.</b>		22d. ADDRESS <b>4890 Battery Lane, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/1/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 2 '60</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

11606

CERTIFICATE OF DEATH

11606

Montgomery

Harvard

Montgomery

Barbados

35 years

Barbados

3327 Wisconsin Avenue

8327 Wisconsin Avenue

John Mary Louise

Hand

March 10, 1935

Female

3/10/35

at 10

Restaurant Owner

Restaurant

Virginia

US

Charles A. Archer

Willie Gray

Yes

James Lind-Bradshaw as 21

No

1

Buried in 1930 Parkview Cemetery, Rockville, Maryland

Robert A. Humphrey, Barbados, Maryland



CERTIFICATE OF DEATH

11507

State of Virginia  
County of Albemarle  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 1st day of January, 1901, at the residence of the deceased, I attended the body of one J. B. Smith, who died of the effects of a heart attack, and I am satisfied that the same was the result of natural causes.  
Witness my hand and seal this 1st day of January, 1901.  
J. B. Smith, M.D.  
Physician

1

Attest:  
J. B. Smith, M.D.  
Physician



Item 2 FilmG273 10-24-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Philomena Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie</b> <b>Harrington</b>		4. DATE OF DEATH <b>October 14th. 1960</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5th. 1877</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Winfield F Overton</b>		14. MOTHER'S MAIDEN NAME <b>Myra Fordham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs Helen Vierling</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>20 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 2, 1959</b> to <b>Oct 14, 1960</b> that I last saw the deceased alive on <b>Oct 5, 1960</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry J. Kucher</b> M.D. <b>5527 Surrey St.</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>H. J. Kucher</b> <b>Cherry Chase, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>10-15-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 18 '60</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11553

CERTIFICATE OF CREDIT

11507

M

Chicago, Ill.

No.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

October 1, 1907

Chicago, Ill.

Chicago, Ill.

June 1, 1907

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11608

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11554

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 years.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5714 Kingswood Rd.</u>		d. STREET ADDRESS <u>15714 Kingswood Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Amanda Harrison</u>		4. DATE OF DEATH Month Day Year <u>October 17 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1983</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>— — — —</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Leatherwood</u>		14. MOTHER'S MAIDEN NAME <u>Rose Day.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary Louise Montgomery</u>		Address <u>5714 Kingswood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia.</u> DUE TO <u>175.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of ovary</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u> <u>9 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>— — 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>— — —</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 13, 1960</u> to <u>October 17, 1960</u> that (I) (we) last saw the deceased alive on <u>October 17, 1960</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Humphreys, Jr. M.D.</u>		22b. DATE SIGNED <u>10/17/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr. M.D.</u>		22d. ADDRESS <u>1746 K St. N.W., Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>October 20, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MORGAN CHAPEL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. WALTZ</u>		ADDRESS <u>Winfield, Maryland</u>	
25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>OCT 19 '60</u>			

11554

CERTIFICATE OF DEATH

11554

Blank document with faint, illegible text impressions.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

11609

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11555

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sil. Sp.</i>	
c. LENGTH OF STAY IN 1b <i>1yr 5mo</i>		14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>13210 Columbia Pike</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Katherine E. Hazen</i>		4. DATE OF DEATH <i>Oct 16 1960</i>	
5. SEX <i>female</i>		6. COLOR OR RACE <i>cauc</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 20 1859</i>	
9. AGE (In years last birthday) <i>101</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brookeville md.</i>	
11. BIRTHPLACE (State or foreign country) <i>91.5</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wm Easton</i>		14. MOTHER'S MAIDEN NAME <i>Margaret</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. George W. Graham</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Apoplexy, thrombosis</i> 420 - 0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>20 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1950</i> to <i>Oct 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 1960</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A.D. Bonifant</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>A.D. BONIFANT</i>		22d. ADDRESS <i>Sandy Spring Md.</i>	
22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-18-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Brookeville</i>		23d. LOCATION (City, town, or county) (State) <i>Brookeville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>		25a. REC'D BY REGISTRAR <i>OCT 19 '60</i>	
ADDRESS <i>Laytonsville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	

0

BP 1

090

(M)

I

1155

1160

(M)

NO

NO

NO

Brooklyn

Brooklyn

Brooklyn

Brooklyn

Brooklyn

Brooklyn

Brooklyn



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11556

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3701 Leland St.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> <b>47X -3</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1435 W St., N.W.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>James Howard</b>		<b>4. DATE OF DEATH</b> Month <b>Oct.</b> <b>17</b> <b>19 60</b> Day Year	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>col</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/13/1894</b>
<b>9. AGE</b> (In years last birthday) <b>65</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles Howard</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>444 M St., N.W.</b>	
<b>17. INFORMANT</b> <b>Jas. O. Howard</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last, (c)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>sudden</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20d. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <b>Frank J. Broschart</b>		<b>DATE SIGNED</b> <b>10/18/60</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10/21/60</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Pleasant.,</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Norbeck, Md.</b>	
<b>23. FUNERAL DIRECTOR</b> <b>Robert L. Snowden</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 24 '60</b>	
<b>ADDRESS</b> <b>Rockville, Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Robert L. Snowden</b>	

11336

11311

THE  
UNITED  
STATES



Monterey

Street 1234

1234 Main St.

1234

1234

1234

1234



1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

1234

11610

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11557

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2936 Cortland Place, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Lutz HOWARD</b>			4. DATE OF DEATH Month Day Year <b>October 12 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-91</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Clement HOWARD</b>			14. MOTHER'S MAIDEN NAME <b>Addie LUTZ</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI-WWII-Kor.</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, retroperitoneal</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, generalized</b> DUE TO (c) <b>Encephalopathy due to arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) <del>person</del> attended the deceased from <b>October 2 1960</b> to <b>October 12 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>October 12 1960</b> , and that death occurred at <b>10:30PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>G. I. Walker, Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-13-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. I. WALKER, JR., CAPT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-17-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler's &amp; Sons</b>		ADDRESS <b>1756 Penn. Ave., NW, WashDC</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11557

11557

U.S. DEPARTMENT OF HEALTH  
CENTRAL OFFICE OF DATA

Director of Statistics

Administrative

Washington

10 days

Belmont (Harris)

1950 Columbia Place, N.W.

U. S. Naval Hospital

Howard

1950

1950

1950

3-8-51

Continental

Washington, D.C.

U.S. Census Bureau

1950

1950

Columbia

1950

1950

1950

1950

1950

1950

1950

1950

U. S. Naval Hospital, Bethesda, Md.

1950

1950

1950

1950

1950

1950

1  
M  
X  
I  
O  
BP-1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
11611  
11558  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>9124-McDonald Dr. Bethesda, Md</b>				c. LENGTH OF STAY IN 1b <b>13yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Franklin Jones</b> <b>XXXXXXHYEY</b>				4. DATE OF DEATH Last <b>HOYLE</b> Month <b>Oct</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1-1870</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Hoyle</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph Hoyle, 4615-Creek Shore Dr. Rockville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>592X</b> IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic NEPHRITIS</b> DUE TO (c) <b>HYPERTENSION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>2 YRS</b> <b>15 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1945</b> to <b>Oct 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 18</b> 19 <b>60</b> , and that death occurred at <b>7:45</b> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo I. O'Donovan MD</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>8214 WISC AVE BETHESDA MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City, town, or county) (State) <b>Beallsville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Beallsville Md</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

11558

CERTIFICATE OF DEATH

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511

11511



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11612

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11559

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>M</b> b. CITY OR TOWN (If outside corporate limits, write <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>53 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Gouverneur</b> c. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>69X-2</b> d. STREET ADDRESS <b>150 Park Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Ernest</b> Last <b>HUNKINS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>19 60</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-23-36</b>		9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>				11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ernest HUNKINS</b>				14. MOTHER'S MAIDEN NAME <b>Lucille WELLS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>120-28-9482</b>		17. INFORMANT <b>(W) Mrs. Elsa M. Hunkins, 101 Farnham Road, Syracuse 4, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, chorionic, testes, with metastases</b> DUE TO <b>178X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) <b>the informant</b> attended the deceased from <b>August 20, 1960</b> to <b>October 12, 1960</b> , that (I) <b>was</b> lost saw the deceased alive on <b>October 12 1960</b> , and that death occurred at <b>7:25AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>B. D. CASTEEL</b>				22b. PHYSICIAN'S NAME (Type) <b>B. D. CASTEEL, CAPT MC USN</b>				22c. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>				22d. DATE SIGNED <b>10-12-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				23b. DATE THEREOF <b>10-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WashDC</b>				23d. LOCATION (City, town, or county) (State) <b>Gouverneur New York</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Funeral Home, 1400 Chapin St., NW</b>				25a. REC'D BY REGISTRAR <b>OCT 14 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Carlton L. House</b>							

11552

CERTIFICATE OF DEATH

11552

Name of Deceased		Rank or Grade		Service	
John Doe		Private		U.S. Army	
Date of Death		Place of Death		Cause of Death	
10-12-1918		New York		Pneumonia	
Age		Sex		Color	
35 years		Male		White	
Date of Birth		Place of Birth		Occupation	
10-12-1883		New York		Farmer	
Date of Admission		Place of Admission		Discharge	
10-12-1918		New York		Discharged	
Date of Death		Place of Death		Cause of Death	
10-12-1918		New York		Pneumonia	
Age		Sex		Color	
35 years		Male		White	
Date of Birth		Place of Birth		Occupation	
10-12-1883		New York		Farmer	
Date of Admission		Place of Admission		Discharge	
10-12-1918		New York		Discharged	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and to any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11613

11560

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>51 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Madison</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Madison</b> d. STREET ADDRESS <b>143 Nathan Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carol</b> Middle <b>Jean</b> Last <b>Hunter</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 15, 1930</b>
9. AGE (In years last birthday) <b>29</b>		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min. <b>29</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. FATHER'S NAME <b>John Casey</b>		14. MOTHER'S MAIDEN NAME <b>Leah Huddy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute lymphocytic leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 2</b> 19 <b>60</b> to <b>October 23</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>October 23</b> 19 <b>60</b> , and that death occurred at <b>9:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward E. Morse</b>		22b. DATE <b>10/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD E. MORSE, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/27/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memory Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Madison, W. Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>		25. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11614

11561

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>21 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b> d. STREET ADDRESS <b>RT. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEAH JANE IGLEHART</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>15</b> Year <b>1960</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/7/1874</b> 9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>NOAH WATKINS</b>				14. MOTHER'S MAIDEN NAME <b>JULIA LINTHICUM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism, bilateral</b> DUE TO <b>463X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombus, right auricle</b> DUE TO (c) <b>Phlebotrombosis right leg</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/24</b> to <b>10/15</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> 19 <b>60</b> , and that death occurred on <b>10/15</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>C. H. LIGON, M. D.</b>				22b. DATE SIGNED <b>10/15/60</b>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS <b>SANDY SPRING, MD.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 18, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Cedar Grove, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				24a. ADDRESS <b>Laytonsville, Md.</b>		24b. REC'D BY REGISTRAR <b>Arthur S. Kraus</b> DATE <b>OCT 19 '60</b>	





11553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>Carroll Hall Sanitorium</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>M.</u> Last <u>ILES</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A.B. Carl</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. Lester A. Pratt (Daughter)</u>		Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 20, 1960</u> , to <u>OCT. 31, 1960</u> , that I last saw the deceased alive on <u>OCT. 31, 1960</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heusen Fowler</u>		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR</u>	
PHYSICIAN'S NAME (Type) <u>CHERY CHASE</u>		DATE <u>10/31/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>-----</u>		22d. LOCATION (City, town, or county) (State) <u>Orlando, Fla.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Fowler's sons</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '60</u>	
ADDRESS <u>1756 Pk. Ave. N.W., Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11503

CERTIFICATE OF DEATH

11553

*[Signature]*  
J. L. Smith

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

11615

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>309 West 28th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Priscilla Brooks Jackson</u>			4. DATE OF DEATH <u>October 12 1960</u> 19		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1898</u> 62 yrs.		9. AGE (In years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Charles Brooks</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs. Leona Asbury (daughter)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Insufficiency</u> (c) <u>Myocardial Infarction</u> Sudden Sudden Sudden					INTERVAL BETWEEN ONSET AND DEATH <u>12-25 AM</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-12-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bru-Transit 10/12/60</u>		22b. DATE THEREOF <u>10/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11616

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11564

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>3212 Parkview Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Richard Dana JOHNSON</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>October 3 1960</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2-1-50</b>	
<b>9. AGE</b> (In years last birthday) <b>10</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hawaii</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Robert Wayne JOHNSON</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Marcy AYLWARD</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>(S-F) Cdr. Roderick L. Harris, USCG, same as #2</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Acute bronchial asthma</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <b>Frank Broschart, M. D.</b>		<b>DATE SIGNED</b> <b>10-3-60</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-7-60</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Arlington Virginia</b>	
<b>23. FUNERAL DIRECTOR</b> <b>Jos. Gawler's &amp; Sons, 1756 Penn. Ave., NW, WashDC</b>		<b>24e. REC'D BY REGISTRAR</b> <b>OCT 5 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

100-100000



111118

111118

MAILED THE 24TH SEPTEMBER 1941

THE 1ST AIRCRAFT CARRIER GROUP, U.S. NAVY, WASHINGTON, D.C.

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118

111118



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
#

11532

11565

1

M

075

1

0

1

AP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>22</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>9411 Biltmore Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Lewis</u> Last <u>Keane</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/26/05</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>model maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Keane</u>				14. MOTHER'S MAIDEN NAME <u>Ella Dent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-03-3464</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal bleeding</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> , 19 <u>60</u> , to <u>10-8</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.		22a. SIGNATURE <u>Dwight R. Smith</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>DWIGHT R. SMITH, M.D.</u> <u>1015 SPRING ST. SIL. SPR. MD.</u>		22b. DATE <u>10-8-60</u> SIGNED <u>14-9-3310</u>	
22d. ADDRESS <u>1015 SPRING ST</u> <u>SIL. SPR. MD.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/11/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Giska</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>	

11555

11555



MADEIRA

POSTAL

11555

11566

11617

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2 hrs.		d. STREET ADDRESS		Box # 1	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		22a. SIGNATURE 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

2074162xvv

113011

RECEIVED

113011

1

*W. A. Johnson*

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11567											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stringtown Rd - (rural)</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u> d. STREET ADDRESS <u>Stringtown Rd.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carl W. King</u>						4. DATE OF DEATH <u>Oct 23 1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1895</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>			
13. FATHER'S NAME <u>John B King</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Burns</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W. # 1 219-07-2553</u>				17. INFORMANT <u>Walden King - Clarksburg md - R-1</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Ft. Myer Virginia</u>			
23. FUNERAL DIRECTOR <u>Frank J. Broschart</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. <u>  </u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-23-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				Address (Street, city, town, or county) <u>  </u>							

INTERVAL BETWEEN ONSET AND DEATH  
Found dead on floor at home

100 STATE  
TAMPA FLA.

1818

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1852





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11619

## CERTIFICATE OF DEATH

11568  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Boyds</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Boyds</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 153</b>				d. STREET ADDRESS <b>Box 153</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>OLIVER</b> Last <b>KNOTT</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/1888</b>		9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>X US</b>
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-2702 A</b>		INFORMANT <b>John G. Knott-Son-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>502.1</b> <b>cor Pulmonale, Acute + Chronic</b> DUE TO <b>5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic Pulmonary Fibrosis + Emphysema</b> DUE TO <b>10 years</b> (c) <b>chronic Bronchitis</b> DUE TO <b>11 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aortic aneurysm</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 May, 1951</b> , to <b>5 October, 1960</b> , that I last saw the deceased alive on <b>5 October, 1960</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above. DATE SIGNED <b>5 Oct 60</b> ADDRESS (Street, city or town, state) <b>Barnesville, Md</b> ACTUAL SIGNATURE <b>Gordon M Smith</b> M.D. <b>Barnesville, Maryland</b> PHYSICIAN'S NAME (Type) <b>Gordon M Smith</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinne</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11502

CERTIFICATE OF DEATH

11610

John A. Brown - born June 15, 1875, died June 15, 1950, at his home, 1234 Main St., Baltimore, Md. Cause of death: Heart disease. Buried in Green-Wood Cemetery, Baltimore, Md.

John A. Brown - born June 15, 1875, died June 15, 1950, at his home, 1234 Main St., Baltimore, Md. Cause of death: Heart disease. Buried in Green-Wood Cemetery, Baltimore, Md.

John A. Brown - born June 15, 1875, died June 15, 1950, at his home, 1234 Main St., Baltimore, Md. Cause of death: Heart disease. Buried in Green-Wood Cemetery, Baltimore, Md.

Arthur S. Kraus

14500

14500

14500

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

U. S. Navy  
U. S. Navy  
U. S. Navy

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

1  
11621

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11570

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Poolesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hickerson</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Partnership Nursing Home</i>				d. STREET ADDRESS <i>Route 1</i>			
3. NAME OF DECEASED (Type or print) First <i>Leona</i> Middle <i>May</i> Last <i>Smithcum</i>				4. DATE OF DEATH Month <i>Oct.</i> Day <i>9</i> Year <i>1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 20, 1885</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>19</i>		11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>home-keeping</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Dickerson, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>John Wallace Cair</i>				14. MOTHER'S MAIDEN NAME <i>Harnet A. Hays</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Eleanor L. White, Hickerson, Md. R-1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>fractured left femur</i> <i>903.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerotic dementia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tipped on rug in her home</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>8</i> o. m. <i>Sep-7</i> 19 <i>60</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Hickerson, Montg-Md</i>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept-2-1960</i> to <i>Oct 9-1960</i> , that (I) (we) lost saw the deceased alive on <i>Oct-8-1960</i> , and that death occurred at <i>6A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>William C. Miller</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>				22d. ADDRESS <i>7 Brooke Ave., Gaithersburg, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 11, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Beallsville Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>				25a. REC'D BY REGISTRAR <i>Oct 11 60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Brand</i>	

I hereby certify that  
 the within and foregoing  
 is a true and correct  
 copy of the original  
 as the same appears  
 from the records of  
 the office of the  
 Registrar of the  
 County of [blank] State of [blank]  
 this [blank] day of [blank] A.D. 19[blank]  
 at [blank] [blank] [blank]  
 [blank] [blank] [blank]

WITNESSED my hand and  
 the seal of said office  
 this [blank] day of [blank] A.D. 19[blank]  
 at [blank] [blank] [blank]  
 [blank] [blank] [blank]  
 [blank] [blank] [blank]



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11622

11571

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>158 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>LOMBARD</b> Last <b>LOMBARD</b>				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-18-92</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James LOMBARD</b>				14. MOTHER'S MIDDLE NAME <b>Sarah BOWSER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WWI</b>			
17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung c metastases</b> 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 16</b> <b>19 60</b> to <b>Oct. 21</b> <b>19 60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 21</b> <b>19 60</b> , and that death occurred at <b>9:55AM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>R. C. THOMAS, LT, MC, USN</b>				22b. DATE SIGNED <b>10-21-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. C. THOMAS, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>10-22-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, South Carolina</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home, 4th &amp; Mass. Aves., N.E., WashDC</b>				25a. REC'D BY REGISTRAR <b>OCT 27 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

1

2

3

051

48X3

M

11271

CERTIFICATE OF DATA

11271

U. S. DEPARTMENT OF HEALTH  
BUREAU OF BACTERIOLOGY  
WASHINGTON, D. C.

TO: Dr. J. H. Henshaw, Jr.,  
U. S. Naval Hospital, Baltimore, Md.

FROM: Dr. J. H. Henshaw, Jr.,  
U. S. Naval Hospital, Baltimore, Md.

SUBJECT: U. S. Navy

DATE: 6-10-32

REMARKS: U. S. Navy

ANALYST: U. S. Navy

TESTS: U. S. Navy

RESULTS: U. S. Navy

CONCLUSIONS: U. S. Navy

SIGNATURE: U. S. Navy

DATE: U. S. Navy

U. S. DEPARTMENT OF HEALTH  
BUREAU OF BACTERIOLOGY  
WASHINGTON, D. C.

11623

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11572

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>51 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>212 37th Place, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Flossie Thelma Lott</b>				4. DATE OF DEATH Month Day Year <b>October 19, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Preston Griffin</b>				14. MOTHER'S MAIDEN NAME <b>Lishia Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremic coma</b> DUE TO <b>Arteriolar nephrosclerosis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriolar nephrosclerosis &amp; Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>50 days</b> <b>years</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>August 29, 1960</b> to <b>October 19, 1960</b> , that (b) (we) last saw the deceased alive on <b>October 19, 1960</b> , and that death occurred at <b>4:45 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas C. Merigan</b>				22b. DATE SIGNED <b>10/20/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Merigan, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Oct. 22, 1960</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Brundage, Ala.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier's Funeral Home, Inc. 585-R.D. 4 P.M.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 24 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11573

CERTIFICATE OF DEATH

11573

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

11508

11573

PRINCE GEO. MONTGOMERY

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9502 SAYBROOK DRIVE</b>		2. USUAL RESIDENCE (Where deceased lived, if not in hospital, give address before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING OXEN HILL</b> d. STREET ADDRESS <b>6671 HOLLY DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>R</b> Last <b>LUCK, Jr.</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/12</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TECHNICAL WRITER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VITRO CORP.</b>	11. BIRTHPLACE (State or foreign country) <b>BOSTON, MASS.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN R. LUCK, SR.</b>	
14. MOTHER'S MAIDEN NAME <b>WANDA unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW # 2</b>	
16. SOCIAL SECURITY NO. <b>WW # 2</b>		17. INFORMANT <b>Mrs. Nancy L. Delozier, 6671 Holly Dr., S.E. Oxen Hill, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct 14-60</b>		22b. DATE THEREOF <b>Oct 14-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR <b>Seniors Bros 1661-9th Hope Rd S E</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>		24c. CHIEF MEDICAL EXAMINER <b>FRANK J. BROSCHE</b>	
24d. DEPUTY MEDICAL EXAMINER <b>Oct 11-1960</b>		24e. DATE SIGNED <b>Oct 11-1960</b>	

11-03



STILLER SPRING

2002 BAYBURN DRIVE

8001 HOLLY DRIVE

OK, TX

OCT

INVEST

MALE



JOHN, TX

YOB

... and a ...



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
11624

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11574

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>73 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>911 Lincoln Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Ray</b> Last <b>Maines</b>				4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 24, 1939</b>	
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
13. FATHER'S NAME <b>Bruce Maines</b>				14. MOTHER'S MAIDEN NAME <b>Anne Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>167-30-4889</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus, right pulmonary artery</b> DUE TO 195.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adrenocortical carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 16, 1960</b> to <b>October 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 16, 1960</b> , and that death occurred <b>10:30am</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Leo Stolbach</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO L. STOLBACH, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lawn Croft Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Linwood, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 21 '60</b>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

5018

1997

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

11533  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11575

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TOWN <u>5da. 9 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San and Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u> d. STREET ADDRESS <u>R.F. J.</u>			
3. NAME OF DECEASED (Type or print) <u>Larry David Mann</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1944</u>		9. AGE (In years last birthday) <u>16</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper-Contractor Carpenter-Contr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Garland Mann</u>			14. MOTHER'S MAIDEN NAME <u>Hilda Fawley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-40-2601</u>		17. INFORMANT <u>Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive epidural hemorrhage (left)</u> DUE TO (c) <u>Fracture of skull</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from ladder and struck head on curbside block</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 10-20 1960</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Side of road</u>			
		20f. (City or town) <u>Montg.</u>		(County) <u>Montg.</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			Address (Street, city, town, or county) <u>10-26-60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>			
				22d. LOCATION (City, town, or country) (State) <u>Damascus, Md.</u>			
23. FUNERAL DIRECTOR <u>Olin L. Mohrman</u>			24a. REC'D BY REGISTRAR <u>OCT 28 '60</u>				
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

MEDICAL CERTIFICATION

DEATH NO. 11-11-77



11-11-77

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and must be retained within 72 hours after death.

4 1 4  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11625

11576

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>23 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>105 Wall St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>THELBERT</b> Middle <b>ASHLEY</b> Last <b>MANNING</b>			4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1960</b> <del>XXXXXX</del>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/02</b>		9. AGE (In years last birthday) <b>58</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>		
17. INFORMANT <b>Lavinia D. Manning-wife-same 2d</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF HEAD OF PANCREAS (METASTASE)</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>14 MONTHS</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 15, 1959</b> to <b>OCT. 22, 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>OCT. 22, 1960</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John N. Tuohy</b>			22b. DATE SIGNED <b>10/22/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. TUOHY, M.D.</b>			22d. ADDRESS <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>10-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HYDEN CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>Hyden</b>		23e. (State) <b>NORTH CAROLINA</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CARCINOMA OF HEAD OF PAN



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
11626 11577														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Glen</u>					c. LENGTH OF STAY in lb <u>5 min.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Walter Reed Annex</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stafford Court House</u>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS <u>R-1 Box 451</u>									
3. NAME OF DECEASED (Type or print) <u>Harlan H. Matter</u>					4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1960</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-23</u>		9. AGE (In years last birthday) <u>37</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>major M-S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>August M. Matter</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>U.S. Army - Records</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>U.S. Army - Records</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>10-25-60</u>														
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> DATE SIGNED <u>10-25-60</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT SAM HOUSTON NATIONAL</u>		22d. LOCATION (City, town, or country) (State) <u>SAN ANTONIO TEXAS</u>								
23. FUNERAL DIRECTOR <u>Rinaldi Funeral Home 816 N. H. N. E. DC 2</u>						24a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>						

THE STATE  
SEALING UNIT

11016

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11016



012830

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>11627</span> <span> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b> </span> <span>11578</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;"> <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nashville</u>				c. LENGTH OF STAY IN 1b <u>months</u>				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>				e. STREET ADDRESS <u>1114 Park Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WINIFRED</u> Middle <u>G.</u> Last <u>MATTIMORE</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>6</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>November 13, 1876</u>		<b>9. AGE</b> (In years lost birthday) <u>83</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Alterations Clerk (Retired)</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Department Store</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Nashville, Tennessee</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John Mattimore</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Kelly</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>412 14 4629A</u>		<b>17. INFORMANT</b> <u>Miss Mary E. Rea (Same as #2)</u>				Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hrs.</u> <u>10 yrs.</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1, 1958</u> <b>to</b> <u>10-6-1960</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10-5-1960</u> <b>and that death occurred at</b> <u>4:15 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Harry J. Kicherer</u>				<b>22b. PHYSICIAN'S NAME (Type)</b> <u>Harry J. Kicherer</u>		<b>22c. ADDRESS</b> <u>5527 Surrey St, Chevy Chase, Md.</u>		<b>22d. DATE</b> <u>Oct 10 '60</u>		<b>22e. SIGNATURE</b> <u>Arthur S. Frank</u>		<b>22f. DATE</b> <u>Oct 10 '60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Oct. 10, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary Cemetery</u>		<b>23d. LOCATION (City, town, or county)</b> <u>Nashville, Tennessee</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Nutter</u>				<b>24b. ADDRESS</b> <u>254 Carroll St NW DC.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>					

MEDICAL CERTIFICATION

090

I

0

1

M

11728

11697

RECEIVED  
CENTRAL OFFICE OF DEATH  
HAWAII AND ALL OTHER TERRITORIES OF THE UNITED STATES

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to discern but appear to include:]*

*[Top section:]* ...  
*[Middle section:]* ...  
*[Bottom section:]* ...

11697

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11554  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11579

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		d. STREET ADDRESS <b>1651 Primrose Road, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Harrison</b> Last <b>Mayers</b>		4. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/15/1865</b>
9. AGE (In years last birthday) <b>95</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Furniture Co. Owner</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George M. Mayers</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Fleming</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Wash, D.C.</b> <b>Mrs. Ruth Mayers Melroy 1651 Primrose Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 Mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 18</b> 19 <b>60</b> , to <b>Oct. 25</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 18</b> 19 <b>60</b> , and that death occurred about <b>5 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold Heiges MD</b>		22b. DATE SIGNED <b>10/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold Heiges MD</b>		22d. ADDRESS <b>1835 E. 57th NW Wash, DC</b>	
23a. BURIAL, CREMATION, or other disposition <b>REMOVED (Special)</b>		23b. DATE THEREOF <b>10/28/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Harris Co. 2901-14 St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

11528

CERTIFICATE OF DEATH

11528

County

City

Residence

1021 Lawrence Road, N.Y.

Age

Years

Months

Days

1915

1915

Sex

Male

Female

Signature

Signature

Date

1915

1915



1915

1915

1915

1915

1915



11628

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11580

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>31 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(Mary Ruth) Baby Girl</u>				4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-60</u>	
9. AGE (In years last birthday) yrs. <u>1 1/2</u>		IF UNDER 1 YEAR Months <u>1 1/2</u> Days <u>12</u> Hours <u>36</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jack W. McBride</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ann Grey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Same as Item #2</u>		17. INFORMANT <u>Father</u> Address <u>Same as Item #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> 760-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intraventricular hemorrhage</u> DUE TO (c) <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 5, 1960</u> to <u>Oct 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 7, 1960</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Alfred S. Norton</u>				22b. DATE SIGNED <u>10-7-60</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 13 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074181XV5

14658

14658

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
BOSTON, MASSACHUSETTS

NAME OF DECEASED  
JACK A. HOLMES

DATE OF DEATH  
JANUARY 15, 1950

PLACE OF DEATH  
BOSTON, MASSACHUSETTS

AGE  
45

SEX  
MALE

RACE  
WHITE

RELIGION  
METHODIST

EDUCATION  
HIGH SCHOOL

OCCUPATION  
ENGINEER

CAUSE OF DEATH  
HEART DISEASE

DATE OF BIRTH  
JANUARY 1, 1905

PLACE OF BIRTH  
BOSTON, MASSACHUSETTS

DATE OF MARRIAGE  
JANUARY 1, 1930

NAME OF SPOUSE  
JANE A. HOLMES

DATE OF INTERMENT  
JANUARY 17, 1950

PLACE OF INTERMENT  
BOSTON, MASSACHUSETTS

DATE OF BURIAL  
JANUARY 17, 1950

PLACE OF BURIAL  
BOSTON, MASSACHUSETTS

DATE OF CREMATION  
JANUARY 17, 1950

PLACE OF CREMATION  
BOSTON, MASSACHUSETTS

DATE OF REINTERMENT  
JANUARY 17, 1950

PLACE OF REINTERMENT  
BOSTON, MASSACHUSETTS

DATE OF REINTERMENT  
JANUARY 17, 1950

PLACE OF REINTERMENT  
BOSTON, MASSACHUSETTS

DATE OF REINTERMENT  
JANUARY 17, 1950

PLACE OF REINTERMENT  
BOSTON, MASSACHUSETTS

DATE OF REINTERMENT  
JANUARY 17, 1950

PLACE OF REINTERMENT  
BOSTON, MASSACHUSETTS

11534

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11581

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>25 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7201 Flower Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>JOSEPH</b> Middle <b>McDONALD</b> Last		4. DATE OF DEATH <b>Oct</b> Month <b>12</b> Day <b>1960</b> Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 21, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitation Dept.,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. McDonald</b>		14. MOTHER'S MAIDEN NAME <b>Ellen O'Connor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW # 1</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Margaret McDonald, 7201 Flower Ave.</b>		Address <b>Takoma Pk., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Hyper-tensive Heart Disease</b> DUE TO (c) <b>24 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 18</b> to <b>Oct 12</b> , 19 <b>60</b> , that (I) <del>was</del> last saw the deceased alive on <b>Oct 11</b> 19 <b>60</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest A. Sarao M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST A. SARAO M.D.</b>		22d. ADDRESS <b>7006 New Hampshire Ave Takoma Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>10/14/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. N. Harris Co. 2901-14 St. N.W. Wash D.C.</b>		25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

© 2000 Blackwell Science Ltd *Journal of Internal Medicine* 247: 399–406

## CERTIFICATE OF DEATH

Reg. Dist. No.

11509

11582

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>		d. STREET ADDRESS <b>110513 Montrose Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lillian</b> First <b>M</b> Middle <b>Merrill</b> Last		4. DATE OF DEATH <b>October</b> Month <b>26</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR <b>7</b> Months <b>23</b> Days <b></b> Hours <b></b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William Payne</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Entwisle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>yes Unknown</b>	
17. INFORMANT <b>Charles M. Merrill-sqj-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia, Severe</b> <b>286.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition, hypoproteinemia</b> DUE TO (c) <b>Chronic debilitation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 24</b> , 19 <b>60</b> to <b>October 26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>October 24</b> , 19 <b>60</b> , and that death occurred at <b>1:30p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>Oct 26, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		<b>Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Oct 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11503

DEPARTMENT OF HEALTH

11503

Montgomery

Montgomery

First Name

Barbara

Last Name

Montgomery Avenue

Address

Montgomery

City

Montgomery

State

Alabama

Household

Washington D. C.

Alfred Payne

Principles of Biology

Unknown

Charles M. Merrill-Johnson

Address

Washington, D. C.

Office of the Director

October 22, 1953

Report

October 22, 1953

Washington, D. C.

10/22/53 - Oak Hill Cemetery

Washington, D. C.

Robert A. Leachery, Bethesda, Maryland



11535

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>418 E. Franklin Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Rose Lea Metter</u>		4. DATE OF DEATH <u>October 30 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-08-06</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR <u>34</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Abraham Metter</u>		14. MOTHER'S MAIDEN NAME <u>Vera Faenick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>561-09-3160</u>	
17. INFORMANT <u>Dister - Mrs. Michael Begab - Silver Spring, Md.</u>		Address <u>418 E. Franklin Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASTHMA, PERENNIAL</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 HOURS</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 24</u> , 19 <u>60</u> , to <u>OCT 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>OCTOBER 30</u> , 19 <u>60</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>		M.D. <u>7733 ALASKA AVENUE NW</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR MD</u>		<u>WASHINGTON 12 D.C.</u>	
22a. BLANKET REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 1-1960</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>WASHINGTON PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Funeral Home</u>		ADDRESS <u>4217-9th NW</u>	
24a. REC'D BY REGISTRAR <u>NOV 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11553

MASSACHUSETTS DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

11553



*[The following text is extremely faint and appears to be bleed-through from the reverse side of the document. It is largely illegible but seems to contain fields for:]*

*Name of Deceased*  
*Age*  
*Sex*  
*Marital Status*  
*Occupation*  
*Place of Birth*  
*Date of Death*  
*Time of Death*  
*Cause of Death*  
*Signature of Physician*  
*Signature of Registrar*

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8500 N. H. Ave</i>		d. STREET ADDRESS <i>8500 NEW HAMPSHIRE AVE</i>	
3. NAME OF DECEASED (Type or print) First <i>Mark</i> Middle Last <i>Meyers</i>		4. DATE OF DEATH Month <i>10</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 27, 1902</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Furniture Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>London England</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Philip Meyers</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Leo Deckelbaum</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiomegaly, Auricular Fibrillation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1960</i> to <i>10-9</i> , 1960, that I last saw the deceased alive on <i>10-8</i> , 1960, and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis Ross</i>		ADDRESS (Street, city or town, state) <i>915-19th St., N.W. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Louis Ross</i>		DATE SIGNED	
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial Oct 10, 1960</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Beth Shalom</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Dargansky &amp; Sons</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 11 '60</i>	
ADDRESS <i>3501-14 St N.W. Wash. D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11629

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11585

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>49 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkley Springs</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>June</b> Middle <b>Viola</b> Last <b>Mills</b>			4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1960</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 17, 1949</b>		9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Clarence J. Mills</b>		14. MOTHER'S MAIDEN NAME <b>June Salmon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.3</b> DUE TO <b>Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Acute Myelogenous Leukemia</b> (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>+ 6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atelectasis, marked</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>1960</b>		20g. (County) <b>Sept. 3</b>		20h. (State) <b>October 22, 1960</b>	
21. I certify that (H) (this hospital) attended the deceased from <b>Sept. 3, 1960</b> to <b>October 22, 1960</b> , that (H) (we) last saw the deceased alive on <b>October 22, 1960</b> , and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert B. Scoggins</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Scoggins, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>10-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenway Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Berkley Springs, W. Va.</b>		23e. (State) <b>W. Va.</b>		23f. (Country) <b>U.S.A.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 25 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. (City, town, or county) <b>Bethesda, Md.</b>			





Page 1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11630

11586

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>175 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>4707 Chevy Chase Drive</b>		1	
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Hayes</b> Last <b>Mitchell</b>				4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-17-96</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Charles W. Hayes</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Paige</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, rt. cerebral hemisphere</b> DUE TO <b>(Primary site undetermined)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Lobular Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 12, 1960</b> to <b>Oct. 4, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 4, 1960</b> , and that death occurred at <b>10:40PM</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>C. W. BRAMLETT, LT, MC, USN</b>				22b. DATE SIGNED <b>10-5-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. W. BRAMLETT, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons</b>				25a. REC'D BY REGISTRAR <b>OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	
24. FUNERAL DIRECTOR'S ADDRESS <b>Joe. Gawler's &amp; Sons, 1756 Penn.Ave.NW, WashDC</b>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
11511										
11587										
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u>			d. STREET ADDRESS <u>1 2001 August Dr</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2001 August Dr</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles William Mohler</u>					4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motion picture projectionist</u>					11. BIRTHPLACE (State or foreign country) <u>Va</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Mohler</u>					14. MOTHER'S MAIDEN NAME <u>Blanche Huntington</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>578-01-5302</u>		17. INFORMANT <u>Elsie Mohler (wife)</u> <u>Stuen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>10/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR NAME (Type) <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>					ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



10

10

100

10

2000

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11631

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11588

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORBECK</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA'S REST HOME</b>		d. STREET ADDRESS <b>4752 EASTERN AVE. N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>L.</b> Last <b>Morris</b>		4. DATE OF DEATH Month <b>10-</b> Day <b>3</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-83</b>
9. AGE (In years lost birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	11. IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES MILLER</b>		14. MOTHER'S MAIDEN NAME <b>JULIA TRACEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>W. CHARLES MORRIS (SAME AS #2)</b>	
17. INFORMANT <b>W. CHARLES MORRIS (SAME AS #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420-0-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>20 years</b> <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5 1957</b> to <b>Oct. 3 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 26 1960</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry J. Kicherer</b>		22b. DATE SIGNED <b>10-3-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry J. Kicherer</b>		22d. ADDRESS <b>5527 Surrey St., Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>Oct 6 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>		25c. ADDRESS <b>WASH. D. C.</b>	
25d. DATE <b>Oct 6 60</b>		25e. ADDRESS <b>3821 14th. ST. N. W.</b>	

11878

CERTIFICATE OF DEATH

11878



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death", and "Date" are faintly visible.]*



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11632

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11589

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>X</b> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>657 Husten Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>V</b> Last <b>Moyer</b>				4. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/08</b>	
9. AGE (In years lost birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert Hayes Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Laura Virginia</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>577-01-6244</b>		17. INFORMANT <b>John A Moyer</b> Address <b>same 2 d Husband</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 2601 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized atherosclerosis</b> DUE TO (c) <b>diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerotic heart disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>7 JULY 1960</b> to <b>10-14-1960</b> that (I) (we) last saw the deceased alive on <b>10-14-1960</b> , and that death occurred at <b>245 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen W. DeJter</b>				22b. DATE SIGNED <b>10-14-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN W. DEJTER, M.D.</b>				22d. ADDRESS <b>6719 WILSON LA., BETHESDA, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. RUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

bp

NY

22

• 24

11512

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11590

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>415 HILLSBORO DRIVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Daniel Henry Murphey, Jr.</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/30/14</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Director of Procurement N.A.S.A.</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>DANIEL H. MURPHEY, SR.</b>				14. MOTHER'S MAIDEN NAME <b>HELEN COSGROVE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW # 2 185-09-6095</b>		17. INFORMANT <b>Mrs. Margaret H. Murphey, 415 Hillsboro Dr. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Coronary Sclerosis</b> DUE TO (c) <b>Undetermined</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Thrombosis (old) 4 months</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1960</b> to <b>Oct 13, 1960</b> , that (I) (we) lost the deceased alive on <b>Sept 17, 1960</b> and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>George L Ball</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct 13, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>George L Ball</b>				22d. ADDRESS <b>10620 Lenox Ave Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 10/17/60</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PHILADELPHIA, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. POMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 19 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Broshardt notified circumstances of this death and he authorized me to sign certificate of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.

Page 4 of this death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

11538

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11591

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> PA. b. COUNTY <u>Montgomery</u> MERCER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>		c. LENGTH OF STAY IN 1b <u>9 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Law &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel NMN NEGREA</u>		4. DATE OF DEATH Month Day Year <u>10 - 9 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-12</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Material Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fabrics</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Negrea</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>278-10-1493</u>	
17. INFORMANT <u>Chart Wash Law &amp; Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEVERE CARDIAC DILATATION</u> (c) <u>Thrombosis Right Iliac Vein</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 OCTOBER 1960</u> to <u>9 OCTOBER 1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>9 OCTOBER 1960</u> , and that death occurred at <u>920</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.		22b. DATE SIGNED <u>9 OCT. 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR., M.D.</u>		22d. ADDRESS <u>7600 CARROLL AVE., TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SHARON, MERCER CO., PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>OCT 11 '60</u>	
25b. REGISTRAR'S SIGNATURE			

1111

CENTRAL OF DEATH

11338

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11559 11592											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. LENGTH OF STAY IN 1b <u>life</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>201 N. Van Buren st.</u>					d. STREET ADDRESS <u>201 N. Van Buren st</u>						
3. NAME OF DECEASED (Type or print) <u>Robert Worth Nicewarmer</u>					4. DATE OF DEATH <u>Oct 27 1960</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-1957</u>		9. AGE (in years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>											
13. FATHER'S NAME <u>Robt. Nicewarmer</u>					14. MOTHER'S MAIDEN NAME <u>Nancy West</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Nancy Nicewarmer - Sister</u> Address <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema with herniation of brain stem</u> DUE TO (b) <u>Anoxia secondary to pulmonary edema</u> DUE TO (c) <u>Pneumonitis, etiology indeterminate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492X</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>days</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>10-27-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>10/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR <u>OCT 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles P. Hume</u>				

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

1150

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11537

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11593

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7517 MAPLE AVE.</u>		d. STREET ADDRESS <u>7517 MAPLE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>NISWANDER</u> Last <u>NISWANDER</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30, 1934</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife &amp; schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Hall Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roland Perry</u>		14. MOTHER'S MAIDEN NAME <u>Marie Savage</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT Address <u>Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO (c) <u>none</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8:25 PM</u> to <u>present</u> that (I) (we) last saw the deceased alive on <u>Oct 19</u> 19 <u>60</u> , and that death occurred at <u>10/23/60</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom</u>		22b. DATE SIGNED <u>Oct 23, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M. D.</u>		22d. ADDRESS <u>10202 Lariston Lane, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 26, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PR. GEO. COUNTY MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. DATE <u>OCT 26 '60</u>	

11581

CERTIFICATE OF DEATH

11581

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11633

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11594

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>74 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10400 Parkwood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>May</b> Last <b>OEHMKE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>19 60</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-21</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas DONAHUE</b>			14. MOTHER'S MAIDEN NAME <b>Mary A. LYONS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>(H) Arthur L. Oehmke, same as #2 above</b>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma breast with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>August 14, 1960</b> to <b>Oct. 27, 1960</b> , that <del>(s)</del> (we) last saw the deceased alive on <b>Oct. 27, 1960</b> , and that death occurred at <b>5:53AM</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>E. J. Rupnik</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-27-60</b>		
22c. PHYSICIAN'S NAME (Type) <b>E. J. RUPNIK, CDR, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-31-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) _____ (State) _____ <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		ADDRESS <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Oehmke</b>

11793

DEPARTMENT OF HEALTH

11833

11793

11833

11833

11793

11833

11833

11793

11833

11793

11833

11833

11833

11793

11833

11833

11833

11793

11833

11793

11833

11793

11833

11793

11793

11793

11793

11793

11793

11793

11793

11793



1  
\$  
(M)  
051  
1  
2  
1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11634  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11595

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>District of Columbia</b> COUNTY <b>47X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>59 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>ELMS</b> Last <b>ORR</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1883</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Jefferson D. ORR</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Elizabeth BRITTEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Walter MOORE</b> (Sister)		Address <b>606 20th. St. S. So. ARLINGTON, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, prostate with metastasis</b> DUE TO (b) <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 4 19 60</b> to <b>October 2 19 60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 2 19 60</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. Hubbard</b>		22b. DATE SIGNED <b>10-3-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. HUBBARD, CDR, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, NNMC, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. HINES</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 5 '60</b>	
ADDRESS <b>Washington, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

•

Chevy Chase, Washington, D. C.

(1971) 1971

3359 Department of Biology

22

• •

1992-1993 1994-1995

07-11-68

— 1 —

1947-1948

880 • J. Neurosci., July 26, 2006 • 26(30):8791–8800

• • • • • (continued)

YOU CAN DO CHARMING

•  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$  •  $\frac{1}{2} \times \frac{1}{3} = \frac{1}{6}$  •  $\frac{1}{3} \times \frac{1}{3} = \frac{1}{9}$  •  $\frac{1}{4} \times \frac{1}{4} = \frac{1}{16}$  •  $\frac{1}{5} \times \frac{1}{5} = \frac{1}{25}$  •  $\frac{1}{6} \times \frac{1}{6} = \frac{1}{36}$  •  $\frac{1}{7} \times \frac{1}{7} = \frac{1}{49}$  •  $\frac{1}{8} \times \frac{1}{8} = \frac{1}{64}$  •  $\frac{1}{9} \times \frac{1}{9} = \frac{1}{81}$  •  $\frac{1}{10} \times \frac{1}{10} = \frac{1}{100}$  •  $\frac{1}{11} \times \frac{1}{11} = \frac{1}{121}$  •  $\frac{1}{12} \times \frac{1}{12} = \frac{1}{144}$  •  $\frac{1}{13} \times \frac{1}{13} = \frac{1}{169}$  •  $\frac{1}{14} \times \frac{1}{14} = \frac{1}{196}$  •  $\frac{1}{15} \times \frac{1}{15} = \frac{1}{225}$  •  $\frac{1}{16} \times \frac{1}{16} = \frac{1}{256}$  •  $\frac{1}{17} \times \frac{1}{17} = \frac{1}{289}$  •  $\frac{1}{18} \times \frac{1}{18} = \frac{1}{324}$  •  $\frac{1}{19} \times \frac{1}{19} = \frac{1}{361}$  •  $\frac{1}{20} \times \frac{1}{20} = \frac{1}{400}$  •  $\frac{1}{21} \times \frac{1}{21} = \frac{1}{441}$  •  $\frac{1}{22} \times \frac{1}{22} = \frac{1}{484}$  •  $\frac{1}{23} \times \frac{1}{23} = \frac{1}{529}$  •  $\frac{1}{24} \times \frac{1}{24} = \frac{1}{576}$  •  $\frac{1}{25} \times \frac{1}{25} = \frac{1}{625}$  •  $\frac{1}{26} \times \frac{1}{26} = \frac{1}{676}$  •  $\frac{1}{27} \times \frac{1}{27} = \frac{1}{729}$  •  $\frac{1}{28} \times \frac{1}{28} = \frac{1}{784}$  •  $\frac{1}{29} \times \frac{1}{29} = \frac{1}{841}$  •  $\frac{1}{30} \times \frac{1}{30} = \frac{1}{900}$  •  $\frac{1}{31} \times \frac{1}{31} = \frac{1}{961}$  •  $\frac{1}{32} \times \frac{1}{32} = \frac{1}{1024}$  •  $\frac{1}{33} \times \frac{1}{33} = \frac{1}{1089}$  •  $\frac{1}{34} \times \frac{1}{34} = \frac{1}{1156}$  •  $\frac{1}{35} \times \frac{1}{35} = \frac{1}{1225}$  •  $\frac{1}{36} \times \frac{1}{36} = \frac{1}{1296}$  •  $\frac{1}{37} \times \frac{1}{37} = \frac{1}{1369}$  •  $\frac{1}{38} \times \frac{1}{38} = \frac{1}{1444}$  •  $\frac{1}{39} \times \frac{1}{39} = \frac{1}{1521}$  •  $\frac{1}{40} \times \frac{1}{40} = \frac{1}{1600}$  •  $\frac{1}{41} \times \frac{1}{41} = \frac{1}{1681}$  •  $\frac{1}{42} \times \frac{1}{42} = \frac{1}{1764}$  •  $\frac{1}{43} \times \frac{1}{43} = \frac{1}{1849}$  •  $\frac{1}{44} \times \frac{1}{44} = \frac{1}{1936}$  •  $\frac{1}{45} \times \frac{1}{45} = \frac{1}{2025}$  •  $\frac{1}{46} \times \frac{1}{46} = \frac{1}{2116}$  •  $\frac{1}{47} \times \frac{1}{47} = \frac{1}{2209}$  •  $\frac{1}{48} \times \frac{1}{48} = \frac{1}{2304}$  •  $\frac{1}{49} \times \frac{1}{49} = \frac{1}{2401}$  •  $\frac{1}{50} \times \frac{1}{50} = \frac{1}{2500}$  •  $\frac{1}{51} \times \frac{1}{51} = \frac{1}{2601}$  •  $\frac{1}{52} \times \frac{1}{52} = \frac{1}{2704}$  •  $\frac{1}{53} \times \frac{1}{53} = \frac{1}{2809}$  •  $\frac{1}{54} \times \frac{1}{54} = \frac{1}{2916}$  •  $\frac{1}{55} \times \frac{1}{55} = \frac{1}{3025}$  •  $\frac{1}{56} \times \frac{1}{56} = \frac{1}{3136}$  •  $\frac{1}{57} \times \frac{1}{57} = \frac{1}{3249}$  •  $\frac{1}{58} \times \frac{1}{58} = \frac{1}{3364}$  •  $\frac{1}{59} \times \frac{1}{59} = \frac{1}{3481}$  •  $\frac{1}{60} \times \frac{1}{60} = \frac{1}{3600}$  •  $\frac{1}{61} \times \frac{1}{61} = \frac{1}{3721}$  •  $\frac{1}{62} \times \frac{1}{62} = \frac{1}{3844}$  •  $\frac{1}{63} \times \frac{1}{63} = \frac{1}{3969}$  •  $\frac{1}{64} \times \frac{1}{64} = \frac{1}{4096}$  •  $\frac{1}{65} \times \frac{1}{65} = \frac{1}{4225}$  •  $\frac{1}{66} \times \frac{1}{66} = \frac{1}{4356}$  •  $\frac{1}{67} \times \frac{1}{67} = \frac{1}{4489}$  •  $\frac{1}{68} \times \frac{1}{68} = \frac{1}{4624}$  •  $\frac{1}{69} \times \frac{1}{69} = \frac{1}{4761}$  •  $\frac{1}{70} \times \frac{1}{70} = \frac{1}{4900}$  •  $\frac{1}{71} \times \frac{1}{71} = \frac{1}{5041}$  •  $\frac{1}{72} \times \frac{1}{72} = \frac{1}{5184}$  •  $\frac{1}{73} \times \frac{1}{73} = \frac{1}{5329}$  •  $\frac{1}{74} \times \frac{1}{74} = \frac{1}{5476}$  •  $\frac{1}{75} \times \frac{1}{75} = \frac{1}{5625}$  •  $\frac{1}{76} \times \frac{1}{76} = \frac{1}{5776}$  •  $\frac{1}{77} \times \frac{1}{77} = \frac{1}{5929}$  •  $\frac{1}{78} \times \frac{1}{78} = \frac{1}{6084}$  •  $\frac{1}{79} \times \frac{1}{79} = \frac{1}{6241}$  •  $\frac{1}{80} \times \frac{1}{80} = \frac{1}{6400}$  •  $\frac{1}{81} \times \frac{1}{81} = \frac{1}{6561}$  •  $\frac{1}{82} \times \frac{1}{82} = \frac{1}{6724}$  •  $\frac{1}{83} \times \frac{1}{83} = \frac{1}{6889}$  •  $\frac{1}{84} \times \frac{1}{84} = \frac{1}{7056}$  •  $\frac{1}{85} \times \frac{1}{85} = \frac{1}{7225}$  •  $\frac{1}{86} \times \frac{1}{86} = \frac{1}{7396}$  •  $\frac{1}{87} \times \frac{1}{87} = \frac{1}{7569}$  •  $\frac{1}{88} \times \frac{1}{88} = \frac{1}{7744}$  •  $\frac{1}{89} \times \frac{1}{89} = \frac{1}{7921}$  •  $\frac{1}{90} \times \frac{1}{90} = \frac{1}{8100}$  •  $\frac{1}{91} \times \frac{1}{91} = \frac{1}{8281}$  •  $\frac{1}{92} \times \frac{1}{92} = \frac{1}{8464}$  •  $\frac{1}{93} \times \frac{1}{93} = \frac{1}{8649}$  •  $\frac{1}{94} \times \frac{1}{94} = \frac{1}{8836}$  •  $\frac{1}{95} \times \frac{1}{95} = \frac{1}{9025}$  •  $\frac{1}{96} \times \frac{1}{96} = \frac{1}{9216}$  •  $\frac{1}{97} \times \frac{1}{97} = \frac{1}{9409}$  •  $\frac{1}{98} \times \frac{1}{98} = \frac{1}{9604}$  •  $\frac{1}{99} \times \frac{1}{99} = \frac{1}{9801}$  •  $\frac{1}{100} \times \frac{1}{100} = \frac{1}{10000}$  •  $\frac{1}{101} \times \frac{1}{101} = \frac{1}{10201}$  •  $\frac{1}{102} \times \frac{1}{102} = \frac{1}{10404}$  •  $\frac{1}{103} \times \frac{1}{103} = \frac{1}{10609}$  •  $\frac{1}{104} \times \frac{1}{104} = \frac{1}{10816}$  •  $\frac{1}{105} \times \frac{1}{105} = \frac{1}{11025}$  •  $\frac{1}{106} \times \frac{1}{106} = \frac{1}{11236}$  •  $\frac{1}{107} \times \frac{1}{107} = \frac{1}{11449}$  •  $\frac{1}{108} \times \frac{1}{108} = \frac{1}{11664}$  •  $\frac{1}{109} \times \frac{1}{109} = \frac{1}{11881}$  •  $\frac{1}{110} \times \frac{1}{110} = \frac{1}{12100}$  •  $\frac{1}{111} \times \frac{1}{111} = \frac{1}{12321}$  •  $\frac{1}{112} \times \frac{1}{112} = \frac{1}{12544}$  •  $\frac{1}{113} \times \frac{1}{113} = \frac{1}{12769}$  •  $\frac{1}{114} \times \frac{1}{114} = \frac{1}{12996}$  •  $\frac{1}{115} \times \frac{1}{115} = \frac{1}{13225}$  •  $\frac{1}{116} \times \frac{1}{116} = \frac{1}{13456}$  •  $\frac{1}{117} \times \frac{1}{117} = \frac{1}{13689}$  •  $\frac{1}{118} \times \frac{1}{118} = \frac{1}{13924}$  •  $\frac{1}{119} \times \frac{1}{119} = \frac{1}{14161}$  •  $\frac{1}{120} \times \frac{1}{120} = \frac{1}{14400}$  •  $\frac{1}{121}$

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochardt notified

MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>																																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>												c. LENGTH OF STAY IN 1b <b>DOA</b>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Bethesda</b>																							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>												d. STREET ADDRESS <b>14900 Battery Lane</b>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Louise</b> Last <b>Pagano</b>												4. DATE OF DEATH Month <b>Oct.</b> Day <b>2</b> Year <b>1960</b>																																			
5. SEX <b>f</b>				6. COLOR OR RACE <b>W</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Jan. 26, 1883</b>				9. AGE (In years last birthday) <b>77</b> yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS. Months Days Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>												10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>												11. BIRTHPLACE (State or foreign country) <b>Italy</b>												12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>											
13. FATHER'S NAME <b>Dominico Bertana</b>												14. MOTHER'S MAIDEN NAME <b>Silvana Odone</b>																																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>												16. SOCIAL SECURITY NO. <b>Unknown</b>												17. INFORMANT <b>Albert G. Crosetto</b> Address <b>4900 Battery L a. Bethesda</b>																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>539.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension, anemia, arthritis</b> DUE TO (c) <b>Dysrhythmia, esophageal + pyloric ulcers, cardiac hypertrophy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a) <b>as above</b>												INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>																																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>				20f. (City or town) (County) (State) <b>—</b>																																			
21. I certify that (I) (this hospital) attended the deceased from <b>July 1955</b> to <b>Oct 2, 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>Oct. 1, 1960</b> , and that death occurred at <b>506</b> M, from the causes and on the date stated above.												22a. SIGNATURE <b>Margaret E. Callan MD</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>Oct. 2, 1960</b>																																			
22c. PHYSICIAN'S NAME (Type) <b>Margaret E. Callan</b>												22d. ADDRESS <b>4700 - Bradley Blvd. Ch. Ch. 15, MD.</b>																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/5/60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>West Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Galeton, Pennsylvania</b>																																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>												25a. REC'D BY REGISTRAR <b>Oct 5 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>																															

11500

11637

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS

## CERTIFICATE OF DEATH

Reg. Dist. No. 11597

11538

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1648.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sant. Hospital</u>				d. STREET ADDRESS <u>3210 Chillum Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Effie</u> First <u>Jane</u> Middle <u>Paine</u> Last				4. DATE OF DEATH <u>Oct. 18</u> 19 <u>60</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6 1871</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Dice</u>				14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Dorathy M. Pain</u> Address <u>3210 Chillum Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral accident.</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Oct. 1960</u> , that I last saw the deceased alive on <u>10/17/60</u> , and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen F. Verges</u> M.D.				ADDRESS (Street, city or town, state) <u>4800-16 St N.W.</u> DATE SIGNED <u>10/19/60</u>			
PHYSICIAN'S NAME (Type) <u>Stephen F. Verges</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-21-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Ga. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
DATE OF BIRTH JANUARY 1, 1900		DATE OF DEATH JANUARY 1, 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS SINGLE		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY NONE		MEDICAL HISTORY NONE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF CLERK (None)	

18



11636

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

11598

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 45			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>6231 Rockhurst Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Rose</u> Last <u>Pearlin</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/89</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Marienberg</u>			
14. MOTHER'S MAIDEN NAME <u>Betta Bravin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Leonard Pearlman, same as above</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Coronary arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Nov. 1957</u> to <u>Oct. 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 20, 1960</u> , and that death occurred at <u>10:23 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Alfred S. Norton</u>				22b. DATE SIGNED <u>Oct. 20, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Alfred S. NORTON, M.D.</u>				22d. ADDRESS <u>4711 - Highland Ave. - Beth. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>10-21-60</u>		<u>CEDAR HILL CREMATORY</u>		<u>SUITLAND - MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Danyansky</u>				25a. REC'D BY REGISTRAR <u>3501-14 St. N.W.</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>OCT 24 '60</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1302

CERTIFICATE OF DEATH

11036

Attest that on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
at \_\_\_\_\_  
I, \_\_\_\_\_  
Minister of the Gospel,  
have received from \_\_\_\_\_  
the following statement of death:  
That \_\_\_\_\_  
aged \_\_\_\_\_ years,  
born \_\_\_\_\_  
at \_\_\_\_\_  
and residing at \_\_\_\_\_  
died on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
at \_\_\_\_\_  
of \_\_\_\_\_  
caused by \_\_\_\_\_  
and that \_\_\_\_\_  
was buried on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
at \_\_\_\_\_  
by \_\_\_\_\_  
Minister of the Gospel.

1

11637

**TO HOSPITAL:** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)  
ISM 9/59

11531

11531

(RECEIVED)

Director of Civil Service

Washington

10-10-30

(10-10-30)

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation

Dear Mr. Hoover:

73

10-10-30

Very truly yours,

W. J. Egan

Special Agent in Charge

Very truly yours,

W. J. Egan

Special Agent in Charge

Special Agent in Charge

11551

## CERTIFICATE OF DEATH

11600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>		d. STREET ADDRESS <b>1339 W. St., S. E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Barbara</b> Last <b>Pieper</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>60</b>	IF UNDER 24 HRS. Hours <b>60</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Pieper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Pyles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Records of Asbury Methodist Home, Gaithersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>several yrs.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10-20</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-16</b> , 19 <b>60</b> , to <b>10-21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>10-20</b> , 19 <b>60</b> , and that death occurred at <b>12-10P</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James W. Egan</b>		DATE SIGNED <b>10/21/60</b>	
PHYSICIAN'S NAME (Type) <b>JAMES W. EGAN</b>		<b>7720 Wisconsin Ave. Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct 24</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>South of Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seneca Bus</b>		ADDRESS <b>1661 Good Hope Rd S.E. Wash 20, D.C.</b>	
24a. REC'D BY REGISTRAR <b>OCT 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• • • • •

10

General Beauregard



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
#  
M  
050  
1  
Y  
11638  
M  
11601  
M  
1  
Y

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>45 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Waverly</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 189</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Sayer</b> Last <b>Post</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1954</b>
9. AGE (In years lost birthday) <b>6</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jack Post</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Schwartz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia</b> DUE TO <b>Acute Lymphatic Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204-2</b> <b>10 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 23, 1960</b> to <b>October 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 7, 1960</b> , and that death occurred at <b>5:50 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward E. Morse</b>		22b. DATE SIGNED <b>10/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward E. Morse, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Abington Hills Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>S. Abington Twnship, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> DATE <b>OCT 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

11001

CERTIFICATE OF DEATH

11134

11134

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Place of Death		Physician		Hospital		Burial Place	
Jan 15, 1945		New York, N.Y.		Dr. J. Smith		St. Mary's		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier	
J. Smith		A. Doe		B. Roe		C. Lee		D. White	

10/1/45  
Robert A. Thompson, Bethesda, Maryland  
10/1/45  
Alphonse M. G. 2, Arlington, Tennessee

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 7/59

FOR STATE  
HEALTH DEPT.

M

X

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11602											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u> c. LENGTH OF STAY IN 1b <u>Emory Grove Rd</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - R-1</u> d. STREET ADDRESS <u>Emory Grove Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Emory Grove Rd</u> <u>Julius</u> First <u>Potts</u> Middle <u>Potts</u> Last				4. DATE OF DEATH <u>Oct 29</u> 19 <u>60</u> Month Day Year							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-1909</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>practical nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Rock Potts</u>				14. MOTHER'S MAIDEN NAME <u>Effie Potts</u> Address <u>Gaithersburg, md R-1</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Effie Potts</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fragmentation of brain</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>shot gun wound</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in head with 16 ga. shot gun</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>1:00</u> p.m. <u>10-29-1960</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Gaithersburg</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
								Address (Street, city, town, or county) <u>10-30-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.</u>				22d. LOCATION (City, town, or country) (State) <u>Gaithersburg, Md.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1908

11830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BY THE  
MEDICAL EXAMINER

(1)

1  
M  
11640  
090  
1  
0

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11603

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Brooke Grove Foundation</u>				d. STREET ADDRESS <u>3130 Wisconsin Ave NW</u>			
3. NAME OF DECEASED (Type or print) <u>Charles DeVault Prather</u>				4. DATE OF DEATH <u>Oct. 1 - 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar 5-1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>McGing - No Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wesley Prather</u>				14. MOTHER'S MAIDEN NAME <u>Julia DeVault</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>918/17-WW1227-204811</u>		17. INFORMANT <u>Hosp. Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Rectum with metastases to liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus (mild)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>9 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9-23-1960</u> to <u>10-1-1960</u> , that (I) (we) last saw the deceased alive on <u>9/30/60</u> and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>C.H. Light</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/1/60</u>		
22c. PHYSICIAN'S NAME (Type) <u>C.H. Light</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>			ADDRESS <u>2901-15th St. NW</u>		25a. REC'D BY REGISTRAR <u>OCT 4 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11013

11013

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

1

2

3

*John J. Smith*  
*John J. Smith*

*John J. Smith*

*John J. Smith*

*John J. Smith*

*John J. Smith*



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
1SM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>31 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>TOBIAS</b> Last <b>PRATHER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/05</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>TOBIAS PRATHER</b>		14. MOTHER'S MAIDEN NAME <b>EDITH MOORE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS,</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>diabetic Coma</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Necrotizing Papillitis (Kidneys)</b> DUE TO (c) <b>Bilateral Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>L. I. Leal</i>		22b. DATE SIGNED <b>10/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/30/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden - Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 31 '60</b>	
25b. REGISTRAR'S SIGNATURE <i>Robert L. Snowden</i>			

1150

1151

MONTGOMERY

NAVY AND

MONTGOMERY

SHORT GROVE

31 MAR.

CLUB

MONTGOMERY GENERAL HOSPITAL

OCTOBER 28

PRATHER

DR. AS

DR. AS

HAIR

NEEDS

NEEDS

22

U.S.A.

MARYLAND

UNEMPLOYED

EDITH MOORE

TOBIAS PRATHER

CLUB, INC.

HOSPITAL RECORDS,

*Latent Print  
Fingerprint  
Latent Print*

2012/20

BALTIMORE, MARYLAND

B. J. LEE, M.D.

CERTIFICATE OF DEATH

Reg. Dist. No.

11539

11605

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY - MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		4-7 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San. Hosp.</u>				d. STREET ADDRESS <u>805 5th Street N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Vern</u> Last <u>Prentice</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-88</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>10</u> Hours <u>6</u> Min.	IF UNDER 24 HRS. Months <u>12</u> Days <u>10</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mission Work</u>		11. BIRTHPLACE (State or foreign country) <u>So. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernette Prentice</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-48-1596</u>		INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-30-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>10</u> Day <u>6</u> Year <u>1960</u> Hour <u>o. m.</u> <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-30</u> , 1960, to <u>10-6</u> , 1960, that I last saw the deceased alive on <u>10-6</u> , 1960, and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>		ADDRESS (Street, city or town, state) <u>7425 Aspen Courts Takoma Park, Md.</u>		DATE SIGNED <u>10-6-60</u>			
PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10

CHIEF CLERK

Wm. H. H.

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some words like "CHIEF CLERK" and "Wm. H. H." are more prominent.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15 (4)  
15M 9/59

11642

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11606

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>West Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>86 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bobby</u> Middle <u>Clayton</u> Last <u>Puckett</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 7, 1957</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Minor child)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ralph E. Puckett</u>		14. MOTHER'S MAIDEN NAME <u>Helen Magyar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO <u>193.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Neuroblastoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> <u>6 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 July</u> 19 <u>60</u> to <u>15 October</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>15 October</u> 19 <u>60</u> , and that death occurred at <u>5:00am</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Vincent H. Bono, Jr.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT H. BONO, JR., M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>10/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u> ADDRESS		25a. REC'D BY REGISTRAR <u>OCI 17 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

11608

11645

DEATH CERTIFICATE

State of New York

(County)

(City)

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10

No. 10



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

1

11643

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11607

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>Idlewood Mobile Manor</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Tracy</b> Middle <b>Lee</b> Last <b>QUINLAN</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>28</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-26-60</b>	
<b>9. AGE</b> (In years last birthday) yrs. <b>2</b>		<b>10. AGE</b> (In years last birthday) yrs. <b>2</b>		<b>11. AGE</b> (In years last birthday) yrs. <b>2</b>		<b>12. AGE</b> (In years last birthday) yrs. <b>2</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) -				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Lawrence W. QUINLAN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Carol Jean BANCK</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>(F) Lawrence W. Quinlan, same as #2 above</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>760.5</b> IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) ( <del>was</del> ) attended the deceased from <b>Oct. 26</b> <b>11:15AM</b> to <b>Oct. 28</b> <b>1960</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Oct. 28</b> <b>1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Fred W. Grello</b>				<b>22b. DATE</b> <b>10-28-60</b>		<b>22c. SIGNATURE</b> <b>Arthur S. Kraus</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Fred W. GRELLO, LT, MC, USN</b>				<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>10-31-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Crematory</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Suitland Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R.A. Pumphrey</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 1 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

2051231XV1

(10.5)  $\frac{1}{2} \log 2$

•

11540

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>Silver Spring</u> 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>10617 Gatewood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>Reamer</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 15, 1960</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Leonard Marcus Reamer</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Holzman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mother</u>		Address <u>10617 Gatewood Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TRANSPOSITION OF GREAT VESSELS FROM HEART</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>-</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that I attended the deceased from <u>OCT 15, 1960</u> , to <u>OCT 17, 1960</u> ; that I last saw the deceased alive on <u>OCT 17, 1960</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 ALASKA AVENUE NW</u> DATE SIGNED <u>OCT 18 1960</u>			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u> M.D.		PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth T. Felo</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>		ADDRESS <u>2100 Eutamia Pl</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11609

11644

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>166 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Orville</b> Last <b>REASONER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-85</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist (Professional)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward REASONER</b>		14. MOTHER'S MAIDEN NAME <b>Louellen ALLEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-48-3287 (SsnL)</b>	
17. INFORMANT <b>Jos. Leo, Jr., same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma hypopharynx</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastases and general debilitation</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 25</b> 19 <b>60</b> to <b>Oct. 8</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 8</b> 19 <b>60</b> , and that death occurred at <b>1:05 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Hansen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James E. Hansen</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 11 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

1954-1955

SECRET (100-1)

... ..



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/59

11645

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8½ days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Richards</u> Last <u>Richards</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 14 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		11. IF UNDER 24 HRS. Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cooperation Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alfred Richards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578015871</u>			
17. INFORMANT <u>Joseph Richards Jr (son)</u> Address <u>6300 Kennedy Dr. Chevy Chase, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leukemia</u> 540.0 DUE TO <u>Gastro-intestinal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ulcer, prepyloric antrum of stomach</u> DUE TO <u>10 days</u> (c) <u>8 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>subtotal gastrectomy; diabetes mellitus; arteriosclerosis, generalized</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 21, 1960</u> to <u>Oct 30, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 30, 1960</u> , and that death occurred on <u>Oct 30, 1960</u> at <u>6:21 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert N. Coale</u>				22b. DATE SIGNED <u>Oct 30, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>				22d. ADDRESS <u>4630 Montgomery Ave. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/2/1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven</u>				23d. LOCATION (City, town, or county) (State) <u>Silver Spring, Mont. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Laufer Sons</u>				25a. REC'D BY REGISTRAR <u>1756 Penna Ave N.W.</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>				DATE <u>NOV 1 '60</u>			

3001

Montgomery  
Bethesda  
Suburban

Joseph  
W

Wash. D.C.  
Washington D.C.  
1951 Lincoln Ave NW

Richards  
Sept. 14 1952 78

Cooperative Southern Washington, Inc  
New Alice Street  
Alfred Richards  
Joseph Richards Jr (son)  
No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

11549

MONTGOMERY

MARYLAND

CHEVY CHASE

4621 LANGDRUM LANE

LACEY F RICKEY

October 10 1960

male white

Retired Economist

Albert Rickey

yes 7/18 to 11/18

Robert F. Richey

4621 Langdrum Lane Chevy Chase, Md.

Coronary Thrombosis

420.1

Brady D. Hodgkins

BRADLEY D. HODGKINS

Burial 10-13-1960

Arlington Nat'l. Cemetery, Arlington, Va.

Joseph Gaudin's Sons, Inc. 1756 Pa. Ave. NW Washington 25

OCT 13 '60

Arthur S. Kraus

11611

1

Page 4

after death.

by the funeral director,

Pages 1 and 2 should be filled with

within 72 hours after death.

M

X

I

0

MEDICAL CERTIFICATION

1. PLACE OF DEATH  
a. COUNTY  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE  
b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First Middle Last  
4. DATE OF DEATH  
Month Day Year  
5. SEX  
6. COLOR OR RACE  
7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH  
9. AGE (In years lost birthday) yrs.  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
11. BIRTHPLACE (State or foreign country)  
12. CITIZEN OF WHAT COUNTRY?  
13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME  
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  
16. SOCIAL SECURITY NO.  
17. INFORMANT  
Address  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b)  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m.  
20d. INJURY OCCURRED  
While of work ☐ Not while of work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from 7:10 9 1936 to Oct 10 1960 that (I) (we) last saw the deceased alive on Oct 7 1960 and that death occurred at 5A M, from the causes and on the date stated above.  
22a. SIGNATURE  
22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type)  
22d. ADDRESS  
23a. BURIAL, CREMATION, REMOVAL (Specify)  
23b. DATE THEREOF  
23c. NAME OF CEMETERY OR CREMATORY  
23d. LOCATION (City, town, or county) (State)  
24. FUNERAL DIRECTOR'S SIGNATURE  
ADDRESS  
25a. REC'D BY REGISTRAR  
DATE  
25b. REGISTRAR'S SIGNATURE

11811

11811

MAINTENANCE AND REPAIRS  
CERTIFICATE OF WORK



Compassing the

11811

11811

11811

11811

11811

11811

11811

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11646

11612

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Nursing Home</u>		c. LENGTH OF STAY IN 1b <u>47 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>4354 Warren St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>RILEY</u>	4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1872</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Renovo, Pennsylvania U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Renovo, Pennsylvania U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Newton Martin</u>		14. MOTHER'S MAIDEN NAME <u>ANNE Pispheon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. E.C. Cash</u>	
17. INFORMANT <u>Mrs. E.C. Cash</u>		Address <u>4354 Warren St. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>10 yrs.</u> (c) <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15, 1946</u> to <u>Oct 19, 1960</u> that (I) <u>last</u> saw the deceased alive at <u>Oct 16, 1960</u> and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.		22b. DATE SIGNED <u>Oct 19, 1960</u>	
22c. PHYSICIAN'S ADDRESS (Type) <u>FRANCIS P. HANNAN, M.D.</u>		22d. ADDRESS <u>1511-17 ST. N.W., WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Washington 9, D.C.</u>		DATE <u>OCT 21 '60</u>	





TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

11647 **MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11613

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P2</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>3906 71st Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Donald</b> Middle <b>(n)</b> Last <b>RISK</b>			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>29</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-31</b>	9. AGE (In years last birthday) <b>29</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Samuel RISK</b>			14. MOTHER'S MAIDEN NAME <b>Jennie DIAMOND</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>424 27 92</b>		17. INFORMANT <b>Mrs. Honor C. RISK, Same as 2d</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory insufficiency</b> DUE TO <b>respirant</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Minor pleural effusions</b> (c) <b>Hodgkin's disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>7 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Herpes Zoster, and Varicella</b> n <b>1</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>60</b>	
20f. (City or town) <b>10-29-</b>		(County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>9-29-</b> <b>1960</b> to <b>10-29-</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>10-29-</b> <b>1960</b> , and that death occurred at <b>5:50AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Russel Miller, Jr. M.D.</b>			22b. DATE SIGNED <b>10-29-60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Russel MILLER, LP, MC, USN</b>			22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>10-31-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>			25a. REC'D BY REGISTRAR <b>NOV 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

11048

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11614

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b> c. LENGTH OF STAY IN 1b <b>over 40 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>13,420 COLUMBIA PIKE ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b> d. STREET ADDRESS <b>13,420 COLUMBIA PIKE ROAD</b>			
3. NAME OF DECEASED (Type or print) <b>ODORION W. ROBY</b>				4. DATE OF DEATH <b>OCT. 6 19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/6/74</b>	
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Politician - Ex County Commissioner</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THOMAS J. ROBY</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET E. MARLOW</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Dena A. Roby, Columbia Pike, Fairland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) <b>420-1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>10/6/60</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE UNION CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR <b>WARNER E. PUMPHREY, INC.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>OCT 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Raymond A. Jaska</b>							

MEDICAL CERTIFICATION

1961

MEDICAL EXAMINATION CERTIFICATE OF DEATH

1961



DEPARTMENT OF HEALTH  
MEDICAL EXAMINATION CERTIFICATE OF DEATH

NAME: THOMAS J. MOY  
RESIDENCE: 1234 N. 10th St., Phoenix, Arizona  
DATE OF BIRTH: 10/15/1915  
DATE OF DEATH: 10/25/1961  
PLACE OF DEATH: Home  
CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural  
SIGNATURE OF PHYSICIAN: [Signature]  
DATE: 10/26/1961  
SIGNATURE OF MEDICAL EXAMINER: [Signature]  
DATE: 10/26/1961



11015

STATE OF OHIO

11015

11015

11015

11015



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11649  
M  
X  
I  
O  
1

11616

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>Bethesda</b> and give nearest town)		c. LENGTH OF STAY IN 1b <b>45</b> <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9914 Ashburton Lane</b>		d. STREET ADDRESS <b>1 9914 Ashburton Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>ABBLETT</b> Last <b>RUMBALL</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Sept. 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William Abblett</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>089-14-6814</b>	
17. INFORMANT <b>John M. Rumball Same As #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO <b>LEFT VENTRICULAR FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (c) <b>15 YRS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL THROMBOSIS - JUNE 10, 1960</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b> <b>3 DAYS</b> <b>15 YRS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>8:30 p. m. OCTOBER 29 1960</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>OCT 26 1960</b> to <b>OCT 29 1960</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>OCT 26 1960</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. O'Connor</b>		22b. DATE SIGNED <b>OCT 29 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. O'CONNOR, M.D.</b>		22d. ADDRESS <b>4861 BATTERY LANE BETHESDA 14, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10-31-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

11611

CERTIFICATE OF DEATH

11611

(2)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

Hans

1  
11650

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11617

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b>		b. COUNTY <b>✓</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>3309 B Gibbs St.</b>		48X-2									
3. NAME OF DECEASED (Type or print) First <b>Gerald</b>		Middle <b>Mc</b>		Last <b>SAMPLE, JR.</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>11</b>		Year <b>19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-60</b>		9. AGE (In years last birthday) — yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>11</b>		IF UNDER 24 HRS. Hours <b>11</b>		Min. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Gerald Mc SAMPLE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>752X</b> IMMEDIATE CAUSE (a) <b>Hydrocephalus, congenital</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Sept. 15 1960, to Oct. 11 1960</b>		(County)		(State)					
21. I certify that (I) (the physician) attended the deceased from <b>Sept. 15 1960</b> , to <b>Oct. 11 1960</b> , that (I) <b>did</b> saw the deceased alive on <b>Oct. 10 1960</b> , and that death occurred at <b>2A</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>J. H. MILLER</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-11-60</b>											
22c. PHYSICIAN'S NAME (Type) <b>J. H. MILLER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>10-12-60</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Jacksonville</b>		(State) <b>Florida</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co., 1400 Chapin St., N.W., WashDC</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									

5101X

—

(1997) 2000

2 of 4 variations

2005年12月10日 星期五

1. 2011

—

• 3 •

120 24 31 821 77 19

11651

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11618

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cora E Saunders</u>				4. DATE OF DEATH <u>October 19, 1960</u>			
5. SEX <u>f</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-82</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Potomac, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>NATHAN W. SAUNDERS</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Clingett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes Unknown</u>		17. INFORMANT <u>Robert L Saunders</u> Address <u>111 North Blvd Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u> DUE TO <u>5 Day post-OR - Valvular Cecum</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Recurrent profuse diarrhea</u> DUE TO <u>Senile tachycardia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/13/60</u> to <u>10/19/60</u> , that (I) (we) last saw the deceased alive on <u>10/18/60</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard Myers MD</u> M.D.				22b. ADDRESS <u>8512 Old Georgetown Rd. Bethesda, Md.</u>		22c. DATE SIGNED <u>10/19/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Ch. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pupphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1151

CENTRAL OF DEATH

1151

Washington

1870 Pacific Street, N.Y.

1

Robert A. Thompson, Secretary, Maryland  
10-21-80  
Baltimore, Md. Secretary, Baltimore



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11652

11619

Item 8 Film 6274 11-21-60 et

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's</b>	
3. NAME OF DECEASED (Type or print) <b>Frank</b>		4. DATE OF DEATH <b>October 20, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-86 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager - Farm -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Savage</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ballenger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>508 Longwood Dr.</b>	
17. INFORMANT <b>Son Frank Savage Jr.</b>		Address <b>Rockville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> 490X DUE TO (b) <b>Pulmonary infarct</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>?</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ronald B. ...</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/22/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Grover Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Baltimore Md</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 25 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

11618

11618

STATE OF DEAN

Received of the Treasurer of the State of New York the sum of \$100.00 for the year 1900.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11653**  
**CERTIFICATE OF DEATH**

**11620**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float:right">b. COUNTY <u>Montgomery</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>30 hours, 6 mins.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>				d. STREET ADDRESS <u>Nichols Lane, Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert</u> Middle <u>Michael</u> Last <u>Scalf</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>2</u> Year <u>19 60</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 1, 1960</u>			
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months <u>1</u>		IF UNDER 24 HRS. Days <u>1</u> Hours <u>1</u> Min. <u>1</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Robert Lee Carter</u>				14. MOTHER'S MAIDEN NAME <u>Betty Lou Parks</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>					
INFORMANT <u>Hospital Records</u>				Address <u>Olney, Maryland</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis of lungs</u> (b) <u>Hemorrhage of liver</u> (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>---</u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Oct. 1, 1960</u> to <u>Oct. 2, 1960</u> , that I last saw the deceased alive on <u>Oct. 2, 1960</u> , and that death occurred at <u>12:55 P</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.				ADDRESS (Street, city or town, state) <u>105 Laurel Ave, Rockville, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Jack Schumacher M.D.</u>				DATE SIGNED <u>10-3-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>				ADDRESS <u>Funeral Home 1331 E. Montg. Ave., Rockville, Md.</u>					
24a. REC'D BY REGISTRAR <u>Oct 6 60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073214xv2

1453

CERTIFICATE OF DEATH

1100

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

SIGNATURE OF MINISTER: [illegible]

SIGNATURE OF CLERK: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

SIGNATURE OF [illegible]: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

11654

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11621

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jean</b> Middle <b>Margaret</b> Last <b>Schulz</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 September 1915</b>
9. AGE (In years lost birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Housewife)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bartel Speet</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Kramer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-20-8674</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Ovarian cystadenocarcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 11, 1960</b> to <b>October 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 16, 1960</b> , and that death occurred <b>4:03am</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent H. Bono Jr</b>		22b. DATE <b>10/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>VINCENT H. BONO, JR., M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-19-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arl. Nat'l. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>		25. REC'D BY REGISTRAR <b>Oct 19 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		25c. ADDRESS <b>5801 Cleveland Ave. Riverdale Md.</b>	

11051

RECEIVED

11051

M

J

11051

11051



11513

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery,</b> MONTGOMERY, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cedarcroft Sanitarium &amp; Hospital Inc.</b>				d. STREET ADDRESS <b>12911 Georgia Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SEYFORD</b> Middle <b>WILLIAM</b> Last <b>SEYFORD</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/28/1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Navy Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>ALBERT SEYFORD</b>				14. MOTHER'S MAIDEN NAME <b>MARIE SCHILDHAUER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		(If yes, give year or dates of service) <b>WW #1 &amp; #2</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Mrs. Mary T. Seyford, 12,911 Ga. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer of the Colon</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Silver Spring, Md.</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>October 2, 1960</b> , to <b>October 28, 1960</b> , that I last saw the deceased alive on <b>Friday 28</b> , 1960, and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Aldo Vacca</b>				ADDRESS (Street, city or town, state) <b>12101 Columbia Pike, Silver Spring, MD</b>			
DATE SIGNED <b>10-30-60</b>							
PHYSICIAN'S NAME (Type) <b>Aldo Vacca, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 4 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10005 Raynor Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>DOMINICK</u> Last <u>Shaw</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/21/08</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l. Mgr. Dairy Industry Supply Ass'n.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Ellen McNichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>086-07-0950</u>		INFORMANT <u>Mrs. Catherine M. Shaw, 10,005 Raynor Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 24</u> , 1959, to <u>Oct 7</u> , 1960, that I last saw the deceased alive on <u>Oct 7</u> , 1960, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw, Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>345 University Blvd, West Oct 7, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>				CITY, TOWN, OR COUNTY (State) <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/10/60</u>		<u>ST. JOHN'S CATH. CEMETERY</u>		<u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Giska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

11823

CERTIFICATE OF DEATH

11823

(11)

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11541

11624

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>22 hrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium - Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>17907 Takoma Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Michael John Sheplee</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-14-41</i>
9. AGE (in years last birthday) <i>19</i> yrs.		10. IF UNDER 1 YEAR Months <i>19</i> Days <i>19</i> Hours <i>19</i> Min.	11. IF UNDER 24 HRS. Months <i>19</i> Days <i>19</i> Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, a. <i>Biologist</i> )		10b. KIND OF BUSINESS OR INDUSTRY <i>Teller - Citizens Throat &amp; Ear</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Sheplee</i>		14. MOTHER'S MAIDEN NAME <i>Sylvia Evanson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-38-5375</i>	
17. INFORMANT <i>Hosp. Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>822X massive subdural hemorrhage</i> DUE TO (b) <i>Cerebral contusion + laceration</i> DUE TO (c) <i>fracture of skull</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Interval between onset and death</i> <i>25 hrs.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of car which left highway</i>		20c. TIME OF INJURY Month, Day, Year <i>10-1 1960</i> Hour <i>11:15</i> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>highway</i>	
20f. (City or town) <i>Silver Spring</i>		20g. County <i>Mont.</i>	
20h. State <i>M.D.</i>		20i. (City or town) <i>Silver Spring</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. BROSCART</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>10-3-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/5/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or country) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>	
23. FUNERAL DIRECTOR <i>Walter E. Pumphrey, Inc.</i>		24a. REC'D BY REGISTRAR <i>Raymond A. Jaska</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimes</i>		24c. DATE <i>OCT 6 '60</i>	

11031

11031

11031

11031

11031-11031

11031-11031

11031



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11655

11625

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> <b>COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>Essex House Conn. Ave. and Davenport</b>	
3. NAME OF DECEASED (Type or print) First <b>Orville</b> Middle <b>Upton</b> Last <b>Singer</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>X-ray specialist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	9. AGE (In years lost birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b> IF UNDER 24 HRS. <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Singer</b>		14. MOTHER'S MAIDEN NAME <b>Nell Willie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Claire A. Singer</b>		Address <b>Essex House, Conn. Ave. &amp; Davenport St. Wash, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO <b>coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary atherosclerosis</b> (c) <b>coronary atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9/30</b> 19 <b>60</b> p. m. <b>10/1</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9/30</b>	20f. (City or town) <b>10/1</b> (County) <b>1960</b> (State) <b>10/1</b>
21. I certify that (I) this hospital attended the deceased from <b>9/30</b> 19 <b>60</b> , to <b>10/1</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>60</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. F. Kreuzburg</b>		22b. DATE SIGNED <b>10/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b>		22d. ADDRESS <b>7852 16th St NW Wash, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>10/4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE <b>OCT 4 '60</b>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1971

CONFIDENTIAL

1103

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15, 14  
ISM 9/56

11656		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND		11626	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>	
c. LENGTH OF STAY IN 1b <b>2 hrs.35min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		d. STREET ADDRESS <b>7 Sextant Green, S.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Michael</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9-30-60</b>		9. AGE (In years lost birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>35</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Freddy E. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Mabel I. JANES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) Freddy E. Smith, same as #2 above</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal Atelectasis</b> <b>762.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> (c) <b>Prematurity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 30, 1960</b> to <b>Oct. 1, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 1, 1960</b> , and that death occurred at <b>2:10AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Fred W. Grello</b> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>10-1-60</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Fred W. GRELLO, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital,</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 10-4-60</b>		23b. DATE THEREOF <b>10-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Ottumwa Iowa</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. PUMPHREY</b> <b>FUNERAL HOME, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 4 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

2051254 XV1

11050

STATE DEPT. OF HEALTH

11050

Division of Health

Division of Health

Washington, D. C.

Washington (D. C.)

1000 1000 1000

1000 1000 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000 1000 1000

1000 1000 1000

( ) 1000 1000 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000 1000 1000

1000 1000 1000

1000

1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

11657

## CERTIFICATE OF DEATH

11627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase 51</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8903 Montgomery Ave.</i>		d. STREET ADDRESS <i>8903 Montgomery Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>William First Arthur Snyder Last</i>		4. DATE OF DEATH <i>Oct. 21 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 13, 1880</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George W. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Trimmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-10-4996</i>	
17. INFORMANT <i>Daughter Mary S. Cookson</i>		Address <i>8903 Montgomery Ave. Chevy Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i> <i>420.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Constrictive heart failure</i> DUE TO (c) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/21, 1960</i> , to <i>10/21, 1960</i> , that I last saw the deceased alive on <i>10/21, 1960</i> , and that death occurred at <i>11:50</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhan</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i> DATE SIGNED <i>10/23/60</i>	
PHYSICIAN'S NAME (Type) <i>John Umhan</i>		<i>Chevy Chase 15 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>burial</i>	<i>10/25/60</i>	<i>Ft. Lincoln Mausoleum</i>	<i>Pr. Geo. Co., Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 24 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Downloaded from <http://ajphaphysocpharm.sagepub.com/> at 11:06 11 April 2015



11542

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11628

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>D.C.</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 47X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hospt.</i>				d. STREET ADDRESS <i>3607 17th St.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Otto</i> Middle <i>NMN</i> Last <i>Solomon</i>				4. DATE OF DEATH Month <i>10</i> Day <i>3</i> Year <i>1960</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-19-83</i>	
9. AGE (In years lost birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Telephone Co.</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>							
13. FATHER'S NAME <i>Samuel Solomon</i>				14. MOTHER'S MAIDEN NAME <i>Suzanna Jenkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>↓</i> Address <i>↓</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Cystitis</i> DUE TO (c) <i>Prostatic hypertrophy</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Parkinson's Disease</i> (b) <i>Carcinoma of Stomach</i> LESSER CAUSATIVE							
INTERVAL BETWEEN ONSET AND DEATH <i>4 da</i> <i>7 da</i> <i>many years</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-22-1960</i> to <i>10-3-1960</i> that (I) (we) last saw the deceased alive on <i>10-3-1960</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>James H. A. [Signature]</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>10-3-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>James H. A. [Signature]</i>				22d. ADDRESS <i>7712 Canall Ave Takoma Park 12 md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-6-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i>				ADDRESS <i>4812 92nd Ave N.W. Wash. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 6 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1198

1198

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

CERTIFICATE OF DEATH

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Name of physician  
6. Name of funeral home  
7. Name of next of kin  
8. Name of informant  
9. Name of registrar  
10. Name of officiating clergyman  
11. Name of officiating minister  
12. Name of officiating priest  
13. Name of officiating rabbi  
14. Name of officiating imam  
15. Name of officiating cantor  
16. Name of officiating cantor  
17. Name of officiating cantor  
18. Name of officiating cantor  
19. Name of officiating cantor  
20. Name of officiating cantor

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1

11543

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11629

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakoma Park</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WASH. SAN &amp; Hosp</i>				d. STREET ADDRESS <i>7114 Woodland Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>HARRY Albert Stacy</i>				4. DATE OF DEATH <i>10/28/60</i>			
5. SEX <i>MALE</i>				6. COLOR OR RACE <i>White</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>3/14/1881</i>			
9. AGE (In years lost birthday) <i>79</i> yrs.				10. # UNDER 1 YEAR Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country) <i>MASS.</i>				12. CITIZEN OF WHAT COUNTRY? <i>America</i>			
13. FATHER'S NAME <i>Albert Stacy</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Crockett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>not Hosp record.</i>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Chl. Reg. myocarditis sec decomp.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i> <i>4 yrs.</i> <i>13 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>3/9/1949</i> to <i>10/28/1960</i> , that (I) (we) last saw the deceased alive on <i>10/28/1960</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard T Morse</i>				22b. DATE SIGNED <i>10/28/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>Howard T Morse</i>				22d. ADDRESS <i>7030 Carroll Ave. Takoma Park Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10/31/60</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>				23d. LOCATION (City, town, or county) (State) <i>Adelphi Prince Georges Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>				25a. REC'D BY REGISTRAR <i>Arthur S. Trana</i>			
25b. REGISTRAR'S SIGNATURE				DATE <i>NOV 1 '60</i>			

11383

11383

GENERAL ORDER



3/11/10

10

10

X

X

For General for General

General for General

11659

MEDICAL CERTIFICATION

**HOSPITAL-ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

15 (4)  
'59

11030

CENTRAL AIR OF CATH

11030

11-1-60 Pleasant View Memory, West Virginia  
Martinsburg, W. Va.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11659

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11631

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton Md.</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>2039 New Hampshire Ave. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>H.</i> Middle <i>Theodore</i> Last <i>Tate</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/28/75</i>
9. AGE (In years lost birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Adm. Asst. to chief</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept.</i>	
11. BIRTHPLACE (State or foreign country) <i>Rutledge, Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Allen S. Tate</i>		14. MOTHER'S MAIDEN NAME <i>Arianna Peck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mary A. Tate</i>		Address <i>same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Cerebral accident (Thrombosis)</i> DUE TO (b) <i>Advanced generalized arteriosclerosis</i> DUE TO (c) <i>arteriosclerotic H.D.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>many years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fall &amp; contused sprain R hip (no fracture)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury on Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> 19 <i>10/23</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>10/22</i> 19 <i>60</i> , and that death occurred at <i>6:15</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard T Sullivan</i> M.D.		22b. DATE SIGNED <i>10/23/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard T Sullivan M.D.</i>		22d. ADDRESS <i>1800- Eye St NW Wash D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE THEREOF <i>10/25/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Emma Jarnigan Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Morristown, Tenn.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		25a. REC'D BY REGISTRAR <i>2901 14th St. N.W. Washington 9, D.C.</i>	
DATE <i>OCT 25 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

11081

11081

RECEIVED  
CENTRAL OFFICE OF THE  
NAVY  
WASHINGTON, D. C.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]*

*[...]* **RECEIVED** *[...]*  
*[...]* **NAVY** *[...]*  
*[...]* **WASHINGTON, D. C.** *[...]*  
*[...]* **RECEIVED** *[...]*  
*[...]* **NAVY** *[...]*  
*[...]* **WASHINGTON, D. C.** *[...]*  
*[...]* **RECEIVED** *[...]*  
*[...]* **NAVY** *[...]*  
*[...]* **WASHINGTON, D. C.** *[...]*

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11515

## CERTIFICATE OF DEATH

11632  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARILEA NURSING HOME</b>		e. STREET ADDRESS <b>10,002 ROGART ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>M N</b> Last <b>TEEHAN</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/4/63</b>
9. AGE (In years last birthday) <b>97</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM J. BARRY</b>		14. MOTHER'S MAIDEN NAME <b>HONORA (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Esther Specht, 10,002 Rogart Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 450.10 DUE TO (b) <b>Senile Arteriosclerosis, Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>1946</b> , 19, to <b>11 Oct 1960</b> , that I last saw the deceased alive on <b>8 Oct.</b> , 19 <b>60</b> , and that death occurred at <b>9 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>H. B. Queen</b> M.D. <b>7112 Willow Ave</b> <b>11 Oct 1960</b> PHYSICIAN'S NAME (Type) <b>H. B. QUEEN</b> <b>TAKOMA PARK, MD</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>10/15/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b> 24a. REC'D BY REGISTRAR DATE <b>OCT 19 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Acute Corporation West Valley  
12/1/12

W.B. QUEEN  
H. J. L. L.  
TAKING POST NO  
MIS William Ave  
11 Oct 1960

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11660

11633

1

M

074

1

0

1

MD

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>M.</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 21, 1893</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bourne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>213-24-7634</u>			
17. INFORMANT <u>Emma J. Thompson (Wife)</u>				Address <u>As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Thrombosis</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/23, 1960</u> to <u>10/16, 1960</u> , that (I) (we) last saw the deceased alive on <u>10/16, 1960</u> , and that death occurred at <u>10/17, 1960</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick Y. Donn</u>				22b. DATE SIGNED <u>10/17/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>				22d. ADDRESS <u>1835 I St., N.W. Wash., D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/19/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Rocklawn</u>				23d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>				25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			
ADDRESS <u>Barneville Md.</u>				DATE <u>OCT 20 '60</u>			

11-11-60

STATE OF TEXAS

11-11-60

(M)



(1)





**1**  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11661

11634

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>10 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Triangle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b> d. STREET ADDRESS <b>148 Wain Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Arthur Earl TOWNE</b>		<b>4. DATE OF DEATH</b> <b>October 1 1960</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>4-14-42</b> <b>9. AGE</b> (In years last birthday) <b>18 yrs.</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Massachusetts</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>George TOWNE</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Elsie SYLVESTER</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>(M) Mrs. R.W. Pethick, 148 Wain Dr., Triangle, Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> DUE TO <b>823 X</b> Conditions, if any, which gave rise to immediate cause (b) <b>-----</b> (a), stating the underlying cause last. <b>-----</b> DUE TO (c) <b>-----</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS</b> <b>PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Was driver of car that left road and struck telephone pole.</b>					
<b>20c. TIME OF INJURY</b> <b>11:58</b> <b>Hour</b> <b>9-30</b> <b>Month, Day, Year</b> <b>19 60</b> <b>20d. INJURY OCCURRED</b> <b>While</b> <input type="checkbox"/> <b>Not While</b> <input checked="" type="checkbox"/> <b>at work</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Marine Base</b> <b>20f. (City or town)</b> <b>Quantico</b> <b>(County)</b> <b>Virginia</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <b>Frank Broschart</b> <b>M.D.</b> <b>EXAMINER'S NAME</b> (Type) <b>Frank Broschart, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>10-1-60</b>		<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>22b. DATE THEREOF</b> <b>Oct. 4 1960</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Nickerson Funeral Home</b> <b>22d. LOCATION</b> (City, town, or country) <b>Bourne</b> <b>(State)</b> <b>Mass.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>J. Dennis Baker</b> <b>Manassas, Va.</b>		<b>24. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Oct 5 '60</b>					

*Arthur L. Hines*

10

1

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

10-1-40

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11544

11635

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>HARRY</b> Last <b>TOWNE</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/79</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRANK H. TOWNE, SR.</b>				14. MOTHER'S MAIDEN NAME <b>LAURA PUMPHREY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>578-18-4896</b>		17. INFORMANT Address <b>Mrs. Ann G. Martinez, 615 A St., N.E. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thromboses</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <b>10/5</b> to <b>10/9</b> 19 <b>60</b> that (I) (we) lost saw the deceased alive on <b>10/8</b> and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Bennett A. Robin</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>10/11/60</b> SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>BENNETT A. ROBIN</b>				22d. ADDRESS <b>317 University Blvd., E., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

11644

CERTIFICATE OF DEATH

11635



## CERTIFICATE OF DEATH

11636

Reg. Dist. No.

11516

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>12 YEARS</u>				d. STREET ADDRESS <u>19411 WIRE AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9411 WIRE AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>MICHAEL</u> Middle <u>ANTONIO</u> Last <u>TOZZOLO</u>		4. DATE OF DEATH		Month <u>10</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 8, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		11. IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTHERN PAIRY</u>			
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>VINCENT TOZZOLO</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-07-4500</u>			
INFORMANT <u>MICHAEL TOZZOLO</u>				Address <u>2102 Cascade Rd. S.S. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>421</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Long standing Cardiac decompensation</u> DUE TO <u>Years</u> (c) <u>Aortic stenosis</u> DUE TO <u>Years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Sept 2, 1958</u> to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard P. Delaney</u>				ADDRESS (Street, city or town, state) <u>4323 Harvard St. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY, M.D.</u>				DATE SIGNED <u>10/14/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Taltavull</u>				ADDRESS <u>3603 14th St. NW. Wash. DC.</u>			
24a. REC'D BY REGISTRAR <u>DATE OCT 13 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Krum</u>			

1  
#  
X  
I  
0  
1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

11545

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11637

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>5718 Ager Rd.</u> b. COUNTY <u>Prince Georges.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Wash. San. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Francis Tucker</u>				4. DATE OF DEATH Month Day Year <u>10 8 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-09</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk, State Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT Address <u>Chart (hospital)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ulcerative Colitis Fulminant</u> DUE TO (b) <u>571-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>approx 20 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 17 1960</u> to <u>Oct 7 1960</u> , that (I) (we) last saw the deceased alive on <u>10/7 1960</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wayne Glickfield</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WAYNE GLICKFIELD M.D.</u>				22d. ADDRESS <u>6826 Riggs Rd. Hyatts. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-12-60</u>		<u>St. Olives</u>		<u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. G. Mattery</u>				ADDRESS <u>131-11th St. S.E.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

11083

STATEMENT OF DEATH  
CERTIFICATE OF DEATH

11083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11662										11638									
MONTGOMERY MARYLAND										MARYLAND MONTGOMERY									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					5. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
5. SEX					6. COLOR OR RACE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH					9. AGE (In years last birthday)					IF UNDER 1 YEAR									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)									
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bunches pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Advanced generalized arteriosclerosis</u> 10 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 3 days														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					(County)					(State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to Oct 1960, that (I) (we) last saw the deceased alive on Oct 30 1960, and that death occurred at 5:20 PM, from the causes and on the date stated above.										22a. SIGNATURE A. D. Bonifant M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT					22d. ADDRESS Sandy Spring, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City, town, or county)					(State)														
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson, Co.					ADDRESS 1300 N ST. N.W. WASH. D.C.					25a. REC'D BY REGISTRAR NOV 2 '60									
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

(M)

051

2

1

11663

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11659

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>59 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83X-3</b> d. STREET ADDRESS <b>1213 Holladay Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>Jean</b> Last <b>TUTHILL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 60</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-25-30</b>	9. AGE (In years last birthday) <b>30</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ira MIDGETT</b>			14. MOTHER'S MAIDEN NAME <b>Rena TILLET</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>(H) Mr. J.R.Tuthill, 12707 Barbara Rd., SS, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma to Liver &amp; Lung</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Primary Carcinoma of Colon</b> DUE TO (c) <b>5 months</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>August 5, 19 60</b>		20g. (County) <b>October 3, 19 60</b>		20h. (State) <b>VA</b>			
21. I certify that (I) <b>(husband)</b> attended the deceased from <b>August 5, 19 60</b> to <b>October 3, 19 60</b> , that (I) <b>(last)</b> saw the deceased alive on <b>October 3, 19 60</b> , and that death occurred at <b>9P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>R. G. Muth</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-3-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-5-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town, or county) <b>Arlington</b>		23e. (State) <b>Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 5 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

viscosity factor

2222

(D) 708, 2004-01-05

1502

Deborah J. Levy, E. A.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

100%

L. J. H. P.

0E-2S-1

• • •

• 10 •

• • • • •



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11664

11640

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1980 Columbia Rd N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSE AQUILINO</u> First <u>- VASCONEZ</u> Middle Last				<b>4. DATE OF DEATH</b> <u>October 15</u> 19 <u>60</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Aug 1891</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Quito, Ecuador</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ecuador</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Military - (RET.) Army of Ecuador</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Quito, Ecuador</u>			
13. FATHER'S NAME <u>Lisardo VASCONEZ</u>				14. MOTHER'S MAIDEN NAME <u>Avelinda VARANJO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>SARA VASCONEZ (Widow)</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma left hemisphere</u> 936.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large substernal thyroid; Hypostatic broncho-</u> <u>pneumonia; severe</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>August 1960</u> to <u>Oct 15</u> 19 <u>60</u> that (I) <u>lost</u> saw the deceased alive on <u>Oct 15</u> 19 <u>60</u> , and that death occurred on <u>2:45 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Michel M. Healy</u> M.D.				22b. DATE SIGNED <u>10-15-60</u>		22c. PHYSICIAN'S NAME (Type) <u>MICHEL M. HEALY</u>	
22d. ADDRESS <u>WASHINGTON CLINIC WASHINGTON 15</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/16/1960</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>QUITO, ECUADOR, SOUTH AMERICA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's Sons</u> ADDRESS <u>1256 Pa. Ave. Wash. D.C. N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

11040

11040

11040

M

(110)

MICHAEL W. HEALY

10/16/2000

UNITED STATES, SOUTH WEST

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11665

11641

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>8 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>				d. STREET ADDRESS <u>14116 Great Oak Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Eugenia</u> Last <u>Walters</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Littleton, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Geo. W. House</u>				14. MOTHER'S MAIDEN NAME <u>Mary Telle</u> Phone No. <u>8-4263</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>A. E. Holmes</u> Address <u>(same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema - secondary to</u> <u>450.0</u> DUE TO <u>Labar Pneumonia + Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sen. art. Sclerotic disease + Smell</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 days</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>16 Feb</u> 19 <u>60</u> to <u>14 Oct</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>14 Oct</u> 19 <u>60</u> and that death occurred at <u>12 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John Bosley Ziegler</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Oct 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				22d. ADDRESS <u>OLNEY, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Oct. 17/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. House</u> ADDRESS <u>254 Carroll St NW</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1903

CENTRAL AIR OF DEATH

1903



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11517

11642

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10402 Hemley Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gustav Henry Weinel</u>				4. DATE OF DEATH Month Day Year <u>Oct 25 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago City Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gustav Weinel</u>				14. MOTHER'S MAIDEN NAME <u>Fredericka Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-26-2785</u>		17. INFORMANT <u>Martha M. Weinel</u> Address <u>10402 Hemley Lane Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X Congestive Heart Failure</u> DUE TO (b) <u>Bronchial Asthma</u> DUE TO (c) <u>5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>Oct 24 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 24 1960</u> , and that death occurred <u>8:25 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John Lawrence Avery</u>				22b. DATE SIGNED <u>Oct 25 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>John L. AVERY</u>				22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		23b. DATE THEREOF <u>10/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEM. PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>EVANSTON, ILLINOIS</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>Oct 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>	

(M)

(I)

(O)

(1)

CERTIFICATE OF DEATH

1912

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
SM 7/59

11560

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11643

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>		d. STREET ADDRESS <u>1208 Monroe st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 Monroe st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry West Wilson</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1884</u>	9. AGE (in years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post office Dept - retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>W. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>James Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bohrer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Catherine Wilson (wife)</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Fund dead in yard</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-27-60</u>	
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or country) <u>Washington, D.C.</u>		(State)	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montg. Ave., Rockville, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



1  
11666  
11644

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chen &amp; Chase</u> <u>54</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmorson Hospital</u>				d. STREET ADDRESS <u>3907 LeLand Street</u> <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>D.</u> Last <u>Worlberg</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3/1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Simon</u>				14. MOTHER'S MAIDEN NAME <u>Ricky Stein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma Morse</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of the Colon</u> DUE TO (c) <u>1 1/2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13, 1960</u> to <u>Oct 9, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 9, 1960</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Antonio Canadas</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO CANADAS, MD.</u>				22d. ADDRESS <u>1835 Eye St. N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 10, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Sanyal &amp; Sons</u>				ADDRESS <u>3501-H 4th</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



## CERTIFICATE OF DEATH

11645  
Reg. Dist. No.

11667

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Poolsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Partnership Rest Home</b>		d. STREET ADDRESS <b>113 A. West Third Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>Maude</b> Last <b>Wood</b>		4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1874</b>
9. AGE (In years last birthday) yrs. <b>86</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Store Clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph H. Trundle</b>		14. MOTHER'S MAIDEN NAME <b>Emily Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. E.O. Gardner</b>		Address <b>207 S. Washington St. Rockville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident, Right</b> DUE TO <b>Cerebral Arteriosclerosis,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>29 Sept, 1960</b> , to <b>24 Oct, 1960</b> , that I last saw the deceased alive on <b>24 Oct, 1960</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		DATE SIGNED <b>24 Oct 60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Gordon M. Smith</b>		M.D. <b>Barnesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-26-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>	
ADDRESS <b>Frederick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11667

11668

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G273 10-26-60 et

## CERTIFICATE OF DEATH

11556

Reg. Dist. No.

11646

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prin. Geo. INTENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>1307 Legation Road Kensington Gardens Nursing Home</u>			
3. NAME OF DECEASED (Type or print) <u>Margaretha</u> First Middle Last				4. DATE OF DEATH <u>Oct 15 1960</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-71</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Edward Halfpap</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Marion Brookbank</u> Address <u>2813 Nicholson st</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis and chronic bronchiectasis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Jan. 29, 1955</u> , to <u>Oct. 15, 1960</u> , that I last saw the deceased alive on <u>Jan. 7, 1960</u> , and that death occurred at <u>one a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter K. Angerine</u> M.D.				ADDRESS (Street, city or town, state) <u>6300-13th St. NW, Wash. D.C. 20015</u> DATE SIGNED <u>10-15-60</u>			
PHYSICIAN'S NAME (Type) <u>Walter K Angerine</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Sent Pleasant Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deol Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



11668

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

11647

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>51 mins.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Alan</b> Last <b>WORTHING</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-60</b>		9. AGE (In years last birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months <b>51</b> Days <b>11</b> Hours <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Daniel James WORTHING</b>				14. MOTHER'S MAIDEN NAME <b>Marguerite Marie PINARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) Daniel J. Worthing, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>782.5 FETAL ATELECTASIS</b> DUE TO (b) <b>IMMATURITY</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <b>51 min.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>51 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>8:39AM</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>person</del> attended the deceased from <b>Oct. 11 8:39AM</b> to <b>Oct. 11 1960</b> , that (I) <del>xx</del> last saw the deceased alive on <b>Oct. 11 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. V. Rack</b>				22b. DATE SIGNED <b>10-11-60</b>		22c. PHYSICIAN'S NAME (Type) <b>R. V. RACK, LT, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>10-13-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Sylvester's</b>		23d. LOCATION (City, town, or county) (State) <b>Graniteville Vermont</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
25c. ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>							

2051261XVO

11668

(1)



1



**\*1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11669

11648

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>Pg.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sharon Nursing Home</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Sharon Nursing Home</i>		d. STREET ADDRESS <i>816 Thurma Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Katie</i> Middle <i>C</i> Last <i>Wright</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>15</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-17-1873</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Beek</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Burroughs.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Nursing Home Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschaw</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschaw</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <i>10-15-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-18-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>
		22d. LOCATION (City, town, or country) (State) <i>Suitland, Md.</i>	
23. FUNERAL DIRECTOR <i>Lee Funeral Home - Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 18 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

MEDICAL CERTIFICATION



M

1

1001 1 80



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i>	b. COUNTY <i>montg</i>				
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brookville</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookville</i>	d. STREET ADDRESS <i>Etchison - Mt. Rd</i>				
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Etchison - Mt. Rd</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3. NAME OF DECEASED (Type or print) <i>Lewis Henry Yinger Jr.</i>	4. DATE OF DEATH Month <i>Oct</i> Day <i>9</i> Year <i>1960</i>				
	5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-10-1892</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brushlayer</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.G.</i>	13. FATHER'S NAME <i>Lewis H. Yinger</i>	14. MOTHER'S MAIDEN NAME <i>Florence M. Phoebe</i>		
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	16. SOCIAL SECURITY NO. <i>W.W. 577-18-1426</i>	17. INFORMANT <i>David C. Yinger - Brookville md</i>	Address <i>Brookville md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage</i> <i>976X</i> DUE TO (b) <i>shot gun wound in mid-chest (heart)</i> DUE TO (c) <i>sudden</i>	INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self-inflicted shot gun wound</i>	20c. TIME OF INJURY Month, Day, Year <i>10-30-1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Brookville Montg md</i>
	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-11-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	22d. LOCATION (City, town, or country) (State) <i>Frederick, Md.</i>	23. FUNERAL DIRECTOR <i>Francis H. Barber</i>	ADDRESS <i>Laytons ville, Md.</i>
	24a. REC'D BY REGISTRAR DATE <i>OCT 13 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	25. EXAMINER'S SIGNATURE <i>Frank J. Broschant</i>	25. DATE SIGNED <i>10-10-60</i>	26. EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>	26. ADDRESS (Street, city, town, or county) <i>10-10-60</i>	27. EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>	27. ADDRESS (Street, city, town, or county) <i>10-10-60</i>

11111

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11111

IN STATE OF NEW YORK



*[Faint, mostly illegible text in the main body of the certificate, likely containing details of the deceased and the medical examination.]*

PROSECUTOR, N. Y.

MR. OLIVER

MR. LILLIBRO

MR. BROWN

NEW YORK, N. Y.

1.

11671

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Colesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilee Rest Home</u>		d. STREET ADDRESS <u>216 W. Montg. Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clara Belle</u> First Middle Last		4. DATE OF DEATH <u>October 20</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/2/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harmon Winner</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-589</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>beccal vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the <u>under-</u> lying cause last. <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 29, 1960</u> to <u>Oct. 20, 1960</u> that I last saw the deceased alive on <u>Oct. 17, 1960</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. Rockville, Md.</u> DATE SIGNED <u>10-20-60</u>	
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gordon Keck</u> ADDRESS <u>1331 E. Montgomery Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

M

090

I

0

1

00

11630

CERTIFICATE OF DEATH

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11630

11672

## CERTIFICATE OF DEATH

11651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>P.G.</i> <i>4320 LAWRENCE ST.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Md</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Capline Nursing Home</i>		d. STREET ADDRESS <i>1644-2</i>	
3. NAME OF DECEASED (Type or print) <i>MARIE</i>		4. DATE OF DEATH Month <i>OCT</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-24-1870</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>turn home</i>	
11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Demme</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Eica</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Eleanor A. Jackson</i>		Address <i>Colmar Manor, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia -</i> <i>153-8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>malnutrition</i> DUE TO (c) <i>Carcinoma of Colon -</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i> <i>6 mo.</i> <i>12 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized - Arterial Sclerosis -</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 Oct</i> , 1960, to <i>13 Oct</i> , 1960, that I last saw the deceased alive on <i>3 Oct</i> , 1960, and that death occurred at <i>2:05 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John B. Ball</i>		M.D. <i>7936 Georgetown Rd.</i>	
PHYSICIAN'S NAME (Type) <i>John G. Ball</i>		<i>Bethesda 14 med.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation-10/13/60.</i>		22b. DATE THEREOF <i>Pittsburg</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pennsylvania</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 17 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)  
15M 9/59

1

11673				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND				11652							
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Cindy</b> Middle <b>Lee</b> Last <b>ZINK</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1960</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-14-60</b>		9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b>		IF UNDER 24 HRS. Hours <b>16</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Henry ZINK</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Ann MAYO</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>S gastroenteritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Viremia</b> DUE TO (c) <b>571.0</b>												INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>5 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Oct. 16 1960</b>		(County) <b>Oct. 30 1960</b>		(State) <b>3:30PM</b>			
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Oct. 16 1960</b> to <b>Oct. 30 1960</b> , that <b>he</b> (we) last saw the deceased alive on <b>Oct. 30 1960</b> , and that death occurred at <b>11:30PM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>L. G. Thorne</b>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>10-31-60</b>							
22c. PHYSICIAN'S NAME (Type) <b>L. G. THORNE, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-2-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) <b>Arlington Virginia</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Everly-Wheatley Funeral Home, Alexandria, Va.</b>				ADDRESS <b>9VVVVVVV XVV</b>				25a. REC'D BY REGISTRAR <b>NOV 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>					

9VVVVVVV XVV

0.212, 0.221,

1997